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

This Provider Agreement (hereinafter "Agreement") is entered into this first day of July, 2019, between the State of Ohio, the Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal office is located in the City of Columbus, County of Franklin, State of Ohio, and _____, MyCare Ohio Plan (hereinafter referred to as MCOP), an Ohio corporation, whose principal office is located in the city of _____, County of _____, State of Ohio.

The MCOP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and agrees to operate as prescribed by Chapter 5167 of the ORC, Chapter 5160-58 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time. Upon request, the MCOP shall submit to ODM any data submitted to ODI to establish the MCOP has adequate provisions against the risk of insolvency as required under 42 CFR (Code of Federal Regulations) 438.116.

The MCOP is an entity eligible to enter into a provider agreement in accordance with 42 CFR 438.3 and is engaged in the business of providing the comprehensive services described in 42 CFR 438.2 through the managed care program for the Medicaid-Medicare eligible population described in OAC rule 5160-58-02 along with any other Medicaid eligible populations authorized by the Centers for Medicare and Medicaid Services (CMS).

The goal of MyCare Ohio is for MCOPs to manage the full continuum of Medicare and Medicaid benefits for their members, providing coordination of long-term care services, behavioral health services, and physical health services. Each MCOP has entered into a Three-Way Contract (Three-Way) with the United States Department of Health and Human Services Centers for Medicare & Medicaid Services and ODM. The Three-Way, which is incorporated as if rewritten herein sets forth comprehensive requirements for MCOPs regarding program operation, enforcement, monitoring, and oversight. If an express conflict exists between the Three-Way and this Agreement, the Three-Way controls.

Dual benefits members, also known as opt-in members, are defined in OAC rule 5160-58-01 as individuals enrolled in an MCOP for whom the MCOP is responsible for the coordination and payment of both Medicare and Medicaid benefits. Medicaid-only members, also known as opt-out members, are defined in OAC rule 5160-58-01 to include individuals enrolled in an MCOP for whom the MCOP is responsible for coordination and payment of only Medicaid benefits. This Agreement applies to both dual benefits members and Medicaid-only members, unless otherwise specified herein.

ODM, as the single state agency designated to administer the Medicaid program under ORC section 5162.03 and Title XIX of the Social Security Act, desires to obtain MCOP services for the benefit of certain Medicaid recipients. In so doing, the MCOP has provided and will continue to provide proof of the MCOP's capability to provide quality services, efficiently, effectively, and economically during the term of this Agreement.

This Agreement is a contract between ODM and the undersigned MCOP pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCOP agrees to provide or arrange for comprehensive Medicaid services through the managed care program as provided in ORC Chapter 5167 and OAC Chapter 5160-58, assuming the risk of loss, and at all times complying with federal and state laws and regulations, federal and state Medicaid program requirements, and other requirements as specified by ODM. This includes without

limitation Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act; and Section 1557 of the Affordable Care Act.

ARTICLE I – GENERAL

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

B. The MCOP agrees to communicate with the Director of the Office of Managed Care (OMC) (hereinafter referred to as OMC) or his or her designee as necessary in order for the MCOP to ensure its understanding of the responsibilities and satisfactory compliance with this Agreement.

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

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

ARTICLE II - TIME OF PERFORMANCE

A. Upon approval by the Director of ODM, this Agreement shall be in effect from the date executed through June 30, 2020 and shall run concurrently with the Three-Way, including any permissible renewals pursuant to Section 5.7 of the Three-Way, unless this Agreement is suspended or terminated pursuant to Article VIII prior to the termination date, or otherwise amended pursuant to Article IX.

ARTICLE III – REIMBURSEMENT

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

ARTICLE IV - RELATIONSHIP OF PARTIES

A. ODM and the MCOP agree that, during the term of this Agreement, the MCOP shall be engaged with ODM solely on an independent contractor basis, and neither the MCOP 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 MCOP shall therefore be responsible for all the MCOP's business expenses, including, but not limited to, employee's wages and salaries, insurance of every type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any.

B. The MCOP 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 MCOP'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 MCOP, the Director of OMC, or other ODM employee who exercises any functions or responsibilities in connection with the review or approval of this Agreement or provision of services under this Agreement shall, prior to the completion of such services or reimbursement, acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with, or would compromise in any manner or degree the discharge and fulfillment of his or her functions and responsibilities with respect to the carrying out of such services. For purposes of this article, "members" does not include individuals whose sole connection with the MCOP is the receipt of services through a health care program offered by the MCOP.

B. The MCOP 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. The MCOP further represents, warrants, and certifies that neither the MCOP nor any of its employees will do or cause any act or omit any action that is inconsistent with such laws.

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

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

E. No officer, member or employee of the MCOP 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 MCOP, along with its officers, members, and employees, understand and agree to take no action, or cause ODM or its employees to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws including without limitation those provisions found in ORC Chapters 102 and 2921.

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

ARTICLE VI - NONDISCRIMINATION OF EMPLOYMENT

A. The MCOP agrees that in the performance of this Agreement or in the hiring of any employees for the performance of services under this Agreement, the MCOP shall not by reason of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry, discriminate against any individual in the employment of an individual who is qualified and available to perform the services to which the Agreement relates.

B. The MCOP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the Agreement on account of race, color, religion, gender, gender identity, 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 5160-58, the MCOP agrees to hold all subcontractors and persons acting on behalf of the MCOP in the performance of services under this Agreement responsible for adhering to the requirements of paragraphs (A) and (B) above and shall include the requirements of paragraphs (A) and (B) above in all subcontracts for services performed under this Agreement.

ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION

A. The MCOP agrees that all records, documents, writings or other information produced by the MCOP under this Agreement and all records, documents, writings or other information used by the MCOP in the performance of this Agreement shall be treated in accordance with OAC rules 5160-58-01.1 and 5160-26-06 and shall be provided to ODM, or its designee, if requested. This includes all records, documents, writings, or other information used by any subcontractors and other delegated entities who have an arrangement for performance under the Agreement which shall also be provided to ODM upon request. The MCOP shall maintain an appropriate record system for services provided to members. The MCOP shall retain all records in accordance with 42 CFR 438.3(u) and comply with the audit and inspection rights of those records in accordance with 42 CFR 438.3(h).

   The MCOP acknowledges that these records, including those of any subcontractors and other delegated entities, may be a part of any Auditor of State audit.

B. All information provided by the MCOP to ODM that is proprietary shall be held to be confidential by ODM. Proprietary information is information which: (a) if made public, would put the MCOP at a disadvantage in the market place and trade of which the MCOP is a part, and (b) meets the definition of “trade secret” as defined in ORC section 1333.61(D). The MCOP agrees to expressly indicate by marking the top or bottom of each individual record containing information the MCOP deems proprietary, regardless of media type (CD-ROM, Excel file etc.), prior to its release to ODM, unless otherwise specified by ODM. Unless otherwise specified by ODM, a record not so expressly indicated by the MCOP as proprietary shall not be held confidential and the MCOP waives any claim that the record is proprietary. Upon request from ODM, the MCOP agrees to promptly notify ODM in writing of the nature of the proprietary information including all reasonable evidence regarding the nature of the proprietary information in records submitted to ODM, and specifically identify the proprietary information contained in each individual record.

   ODM will not share or otherwise disclose proprietary information received from the MCOP to any third party without the express written authorization of the MCOP, except that ODM shall be permitted to share

proprietary information with the Auditor of State or contracted entities who need the proprietary information for rate setting or other purposes connected to the administration of the Medicaid program. These contracted entities shall be bound by the same standards of confidentiality that apply to ODM in these situations. In addition, ODM is also permitted to disclose proprietary information in response to court orders. Prior to disclosure of proprietary information required by court order (unless otherwise ordered by the court), ODM shall reasonably promptly notify the MCOP in writing of the order and the proprietary information that would be released.

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

The provisions of this Article are not self-executing.

C. The MCOP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Agreement. The MCOP 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 section 5160.45, as well as 42 CFR Part 2 and ORC section 5119.27, as applicable. The terms of this section shall be included in any subcontracts executed by the MCOP for services under this Agreement. The MCOP shall implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements cited above, as well as those set forth in 45 CFR Parts 160 and 164.

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

E. All records relating to performance under or pertaining to this Agreement will be retained by the MCOP in accordance to the appropriate records retention schedule. Pursuant to 42 CFR 438.3(u) and 42 CFR 438.3(h), the appropriate records retention schedule for this Agreement is for a total period of 10 years as are the audit and inspection rights for those records. For the initial three years of the retention period, the records shall be stored in a manner and place that provides readily available access. If any records are destroyed prior to the date as determined by the appropriate records retention schedule, the MCOP 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 MCOP 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 MCOP to keep the records longer then the approved records retention schedule. The

MCOP will be notified by ODM when the litigation hold ends, and retention can resume based on the approved records retention schedule. If the MCOP fails to retain the pertinent records after receiving a litigation hold from ODM, the MCOP 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 MCOP shall promptly notify ODM of any legal matters and administrative proceedings including, but not limited to, litigation and arbitration, which involve or otherwise pertain to the activities performed pursuant to this Agreement and any third party. In the event that the MCOP possesses or has access to information and/or documentation needed by ODM with regard to the above, the MCOP agrees to cooperate with ODM in gathering and promptly providing such information and/or documentation to the extent permissible under applicable law.

ARTICLE VIII - NONRENEWAL AND TERMINATION

A. This Agreement may be terminated, pursuant to Section 5.5 of the Three-Way or by ODM or the MCOP 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. If the Three-Way is terminated, and ODM decides to enter into a new Agreement with the MCOP, MCOP shall be required to enter into a new Agreement with ODM that shall begin the day after the termination of the Three-Way. By executing this Agreement, MCOP expressly agrees to be bound by this provision of the Agreement. If the option to enter into a new Agreement per this Section is exercised, the MCOP will be provided a copy of the proposed new Agreement for review prior to execution. The terms of the new Agreement will not be unconscionable or capricious and the parties agree to negotiate in good faith.

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

C. In the event of termination under this Article, the MCOP shall be entitled to request reconciliation of reimbursements through the final month for which services were provided under this Agreement, in accordance with the reimbursement provisions of this Agreement. The MCOP 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, MCOP shall return all records in their native format relating to cost, work performed, supporting documentation for invoices submitted to ODM, and copies of all materials produced under or pertaining to this Agreement.

E. ODM may, in its sole discretion, terminate or fail to renew this Agreement if the MCOP or MCOP's subcontractors violate or fail to comply with the provisions of this Agreement or other provisions of law or regulation governing the Medicaid program. 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 may apply Pursuant to ORC section 5164.38, the MCOP does not have the right to request an adjudication hearing under ORC Chapter 119 to challenge any action taken or decision made by ODM with respect to entering into or refusing to enter into a provider agreement with the MCOP pursuant to ORC Section 5167.10.

F. The MCOP understands that availability of funds to fulfill the terms of this Agreement is contingent on appropriations made by the Ohio General Assembly and the 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, Covered Families and Children, or Adult Extension) to fulfill the terms of this Agreement, the obligations, duties, and responsibilities of the parties with respect to that population will be terminated except as specified in Appendix P as of the date funding expires. If the Ohio General Assembly or the United States government fails at any time to provide sufficient funding for ODM or the State of Ohio to make payments due under this Agreement, this Agreement will terminate as of the date funding expires without further obligation of ODM or the State of Ohio.

ARTICLE IX - AMENDMENT AND RENEWAL

A. This Agreement may be amended only by a writing signed by both parties. Any written amendments to this Agreement shall be prospective in nature.

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

ARTICLE X - LIMITATION OF LIABILITY

A. The MCOP agrees to (1) pay for the defense (if requested by ODM) of ODM and the State of Ohio and any of its agencies, and (2) to indemnify and to hold ODM and the State of Ohio and any of its agencies harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of the MCOP in the fulfillment of this Agreement or arising from this Agreement which are attributable to the MCOP's own actions or omissions, or of those of its trustees, officers, employees, agents, subcontractors, suppliers, third parties utilized by the MCOP, or joint ventures'. Such claims shall include but are not limited to: any claims by providers or Medicaid recipients, any claims made under the Fair Labor Standards Act or under any other federal or state law involving wages, overtime, or employment matters and any claims involving patents, copyrights, trademarks, and applicable public records laws. The MCOP shall be responsible for any pay all legal fees, expert and consulting fees, expenses, and costs associated with defending ODM and the State of Ohio and its agencies against these claims. In any such litigation or claim, ODM and the State of Ohio and its agencies shall have the right to choose their own legal counsel and any experts and consultants, subject only to the requirement that legal, expert, and consulting fees must be reasonable.

B. The MCOP 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 MCOP or its subcontractors during the term of this Agreement, including but not limited to the nonperformance of the duties and obligations to which the MCOP has agreed under this Agreement.

C. In the event that, due to circumstances not reasonably within the control of the MCOP or ODM, a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection occurs, neither ODM nor the MCOP will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided that so long as the MCOP's Certificate of

Authority remains in full force and effect, the MCOP shall be liable for the covered services required to be provided or arranged for in accordance with this Agreement.

D. In no event shall ODM be liable for indirect, consequential, incidental, special or punitive damages, or lost profits.

ARTICLE XI - ASSIGNMENT

A. Medicaid members may not be transferred by one MCOP 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 MCOPs outside the normal open enrollment process and implement an assignment process as ODM determines is appropriate. Any member transfer shall be submitted for ODM's review 120 calendar days prior to the desired effective date. ODM shall use reasonable efforts to respond to any such request for approval within the 120-calendar day period. Failure of ODM to act on a request for approval within the 120-calendar day period does not act as an approval of the request. ODM may require a receiving MCOP to successfully complete a readiness review process before the transfer of members under this Agreement.

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

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

ARTICLE XII - CERTIFICATION MADE BY THE MCOP

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

B. The MCOP certifies that no federal funds paid to the MCOP through this or any other Agreement with ODM 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 MCOP 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 MCOP has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. This certification is material representation of fact upon which reliance was placed when this Agreement was entered into.

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

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

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

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

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

I. The MCOP, 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 MCOP will make a good faith effort to ensure that all MCOP officers, employees, members, and subcontractors will not purchase, transfer, use or possess illegal drugs or alcohol, or abuse prescribed drugs in any way while performing their duties under this Agreement.

J. The MCOP certifies and confirms that any performance of experimental, developmental, or research work

shall provide for the rights of the Federal Government and the recipient in any resulting invention.

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

ARTICLE XIII - CONSTRUCTION

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

ARTICLE XIV - INCORPORATION BY REFERENCE

A. OAC Chapter 5160-58, the Three-Way, and the MyCare Ohio Compliance Methodology document (Compliance Methodology) are hereby incorporated by reference as part of this Agreement having the full force and effect as if specifically restated herein.

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

C. In the event of inconsistence or ambiguity between the provisions of OAC Chapter 5160-58, and this Agreement, the provisions of OAC Chapter 5160-58 shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, pursuant to the order of precedence established in Section 5.6 of the Three-Way. In the event OAC Chapter 5160-58 is silent with respect to any ambiguity or inconsistency, the Agreement (including Appendices), shall be determinative of the obligations of the parties, unless otherwise stated herein. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the Agreement and the budgetary and statutory constraints of ODM.

ARTICLE XV – NOTICES

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

ARTICLE XVI – HEADINGS

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

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.

MCOP NAME

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

THE OHIO DEPARTMENT OF MEDICAID

BY: _____ DATE: _____
MAUREEN M. CORCORAN, DIRECTOR
50 West Town Street, Suite 400, Columbus, Ohio 43215

Ohio Department of Medicaid (ODM)
MyCare Ohio Provider Agreement
Table of Contents

APPENDIX	TITLE
APPENDIX A	OAC RULES
APPENDIX B	SERVICE AREA SPECIFICATIONS
APPENDIX C	PLAN RESPONSIBILITIES
APPENDIX D	ODM RESPONSIBILITIES
APPENDIX E	RATE METHODOLOGY
APPENDIX F	MARKETING AND MEMBER COMMUNICATIONS
APPENDIX G	COVERAGE AND SERVICES
APPENDIX H	PROVIDER PANEL SPECIFICATIONS
APPENDIX I	PROGRAM INTEGRITY
APPENDIX J	FINANCIAL PERFORMANCE
APPENDIX K	QUALITY CARE
APPENDIX L	DATA QUALITY
APPENDIX M	QUALITY & WAIVER PERFORMANCE MEASURES AND STANDARDS
APPENDIX N	COMPLIANCE ASSESSMENT SYSTEM
APPENDIX O	QUALITY WITHHOLDS
APPENDIX P	PLAN TERMINATIONS/NONRENEWALS
APPENDIX Q	PAYMENT REFORM

APPENDIX A

OAC RULES

1. The MyCare Ohio managed care program rules are located in Ohio Administrative Code (OAC) Chapters 5160-26 and 5160-58 and can be accessed electronically through the Ohio Department of Medicaid's Managed Care webpage.

2. **Distribution List Subscriptions.** The MCOP shall subscribe to the appropriate distribution lists for notification of all OAC rule clearances, final rules published with medical assistance letters (MALs), Medicaid handbook transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. The MCOP 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 email addresses maintained on those distribution lists. Email distribution lists include:

    a. RuleWatch Ohio at: https://www.rulewatchohio.gov/home?1; and

    b. ODM Rule Notification at: https://medicaid.ohio.gov/RESOURCES/Legal-and-Contracts/Rules

APPENDIX B

SERVICE AREA SPECIFICATIONS

MYCARE OHIO PLAN:

1. **Service Areas.** The MyCare Ohio Plan agrees to provide Medicaid services to individuals dually eligible for Medicare and Medicaid pursuant to OAC rule 5160-58-02 residing in the following service areas:

   Service Area Regions

Central	☐
East Central	☐
Northeast	☐
Northeast Central	☐
Northwest	☐
West Central	☐
Southwest	☐

   The MyCare Ohio Plan shall serve all counties in any region they agree to serve.

2. **MyCare Ohio Plan Service Area Regions.** The MyCare Ohio Program consists of 29 counties grouped into seven service area regions identified below.

   a. **Counties in Central.** Delaware, Franklin, Madison, Pickaway, and Union.

   b. **Counties in East Central.** Portage, Stark, Summit, and Wayne.

   c. **Counties in Northeast.** Cuyahoga, Geauga, Lake, Lorain, and Medina.

   d. **Counties in Northeast Central.** Columbiana, Mahoning, and Trumbull.

   e. **Counties in Northwest.** Fulton, Lucas, Ottawa, and Wood.

   f. **Counties in West Central.** Clark, Greene, and Montgomery.

   g. **Counties in Southwest.** Butler, Clermont, Clinton, Hamilton, and Warren.

APPENDIX C

PLAN RESPONSIBILITIES

The following are MyCare Ohio Plan (MCOP) responsibilities not otherwise stated in OAC rule or elsewhere in this Agreement.

1. The MCOP shall implement program modifications as soon as reasonably possible but later than the required effective date, in response to changes in applicable state and federal laws and regulations.

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

3. The MCOP shall designate the following:

    a. A primary contact person, the Contract Compliance Officer, as specified in Sections 2.2.2.1 and 2.2.3.4.1.3 of the Three-Way, who will dedicate a majority of his or her time to the MyCare Ohio (Medicaid-Medicare) product line and coordinate overall communication between ODM and the MCOP. ODM may also require the MCOP to designate contact staff for specific program areas. The Contract Compliance Officer will be responsible for ensuring the timeliness, accuracy, completeness, and responsiveness of all MCOP submissions to ODM.

    b. A provider relations representative for each service area included in this Agreement. Each provider relations representative can serve in this capacity for only one service area.

4. **Communications.** In addition to Section 2.2 of the Three-way, the MCOP shall take all necessary and appropriate steps to ensure all MCOP staff are aware of, and follow, the following communication process:

    a. All MCOP employees are to direct all day-to-day submissions and communications to their ODM-designated contract administrator within the Office of Managed Care (OMC) unless otherwise notified by ODM. If the MCOP needs to contact another area of ODM in any other circumstance, the contract administrator within the OMC shall also be copied or otherwise included in the communication.

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

    c. Because the MCOP is ultimately responsible for meeting program requirements, ODM will only discuss MCOP issues with the MCOP's subcontractor when the MCOP is also participating in the discussion or when the MCOP grants ODM permission to do so. MCOP subcontractors should communicate with ODM when the MCOP is participating or when the MCOP grants the subcontractor authorization to communicate directly with ODM.

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

6. The MCOP shall have a MyCare Ohio Medicaid Managed Care program administrative office located in Ohio.

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

8. **Required MCOP Staff.** The MCOP shall have the key MyCare Ohio Medicaid Managed Care program staff specified in Section 2.2.3 of the Three-Way based and working in the state of Ohio. Each key staff person identified in Section 2.2.3 of the Three-Way may occupy no more than one of the positions, unless the MCOP receives prior written approval from ODM stating otherwise.

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

10. The MCOP shall have all new employees trained on applicable program requirements including those in the Three-Way, and represent, warrant, and certify to ODM that such training occurs, or has occurred. Plans shall conduct staff training sessions on subjects including disability competency, access, cultural sensitivity, person-centered care delivery approaches and independent living philosophies.

11. All employees of the MCOP and the MCOP's delegated/subcontracted entities who have in-person contact with members in their home shall comply with criminal record check requirements as specified by ODM.

12. If the MCOP determines it does not wish to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, it shall immediately notify ODM to coordinate the implementation of this change. The MCOP will be required to notify its members of this change at least 30 calendar days prior to the effective date. The MCOP's member handbook and provider directory, as well as all marketing materials, will need to include information specifying any such services the MCOP will not provide.

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

14. The MCOP is responsible for determining medical necessity for services and supplies requested for its members as specified in OAC rule 5160-58-03. Notwithstanding such responsibility, ODM retains the right to make the final determination on medical necessity in specific member situations.

15. In addition to the timely submission of medical records at no cost for the annual external quality review, the MCOP may be required to submit medical records at no cost to ODM and/or its designee upon request.

16. **Provider Panel Changes.** In addition to Section 2.6.1.2 of the Three-Way, the MCOP shall comply with the requirements set forth in OAC rules 5160-58-01.1 and 5160-26-05, and shall notify the OMC:

    a. Within one business day of becoming aware that an MCOP panel provider which served 100 or more of the MCOP's members in the previous 12 months failed to notify the MCOP they are no longer available to serve as an MCOP 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 MCOP-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 100 or more of the MCOP's members in the previous 12 months. For example, the MCOP terminates 10 providers each serving 25 members. This termination shall be reported, even though the providers individually do not meet the 100-member requirement. Overall, the group termination impacts 250 members and shall be reported. ODM reserves the right to require the MCOP to align an MCOP-initiated systemic change in panel to the annual open enrollment month;

    c. Prior to any MCOP-initiated provider panel changes that will or may result in provider network availability being reduced by 10% or more of available panel providers as of the date of the notice. MCOP-initiated changes may include, but are not limited to, restricting contracts for any service or with any providers by limiting subcontracts (including sole source contracting), terminating or restricting any providers or group of providers or by reducing payment rates; or

    d. Within one business day of becoming aware of a provider-initiated hospital unit closure.

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

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

        ii. Copy of the termination notice including the termination date;

        iii. Number of members who used services from, or were assigned to, a PCP in the previous 12 months; and

        iv. Results of an evaluation of the remaining contracts completed to assure adequate access, including the average and longest distance a member will need to travel to another provider, and the name, provider type, address, and county of the remaining contracts that can meet the access requirements.

        v. For hospital terminations:

1. Zip codes or counties of residence for members who used services in the previous 12 months;

2. Percentage of the plans' membership that use the terminating hospital and compare with the percent of the plans' membership that use the next closest contract hospital; and

3. Plan to ensure continuity of services for members in their third trimester, receiving chemotherapy, and/or receiving radiation treatment.

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

    a. The MCOP is required to make transportation available to any member requesting transportation when the member shall travel 30 miles or more from his or her home to receive a medically-necessary Medicaid-covered service provided by the MCOP pursuant to OAC rule 5160-58-03 and Appendix G of this Agreement. If the MCOP offers transportation to its 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 MCOP shall give ODM and members 90 calendar days prior notice when decreasing or ceasing any additional benefits. When the MCOP finds it is impossible to provide 90 calendar days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, ODM shall be notified within at least one business day.

18. **Behavioral Health Crisis Services**. The MCOP shall ensure protocols, policies, and processes are in place for MCOP and/or delegated staff to appropriately address member contacts related to behavioral health crisis needs. Protocols shall include, at a minimum, the involvement of qualified health professionals whose scope of practice and licensure permits them to perform the required functions associated with the services. Staff shall have: experience with behavioral health crisis assessment and intervention as applicable, a mechanism to validate the individual received the needed services (e.g. connection to crisis counseling services), and the ability to activate the MCOP's process 24/7.

19. **Provision of Transportation Services.** The MCOP shall ensure transportation pick-up is completed not more than 15 minutes before or 15 minutes after the pre-scheduled pick-up time, ensuring the member is on time for their appointment. Following a scheduled appointment, transportation pick-up shall be completed no more than 30 minutes after a request for pick-up.

a. The transportation vendor shall attempt to contact the member if he or she does not respond at pick-up. The vendor shall not leave the pick-up location prior to the pre-scheduled pick-up time.

b. The MCOP shall identify and accommodate any special transportation assistance needs of its members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements). Member-specific needs shall be communicated to the transportation vendor and updated as frequently as is needed to support the member's needs. Where applicable, these needs shall be documented in the member's care plan.

c. Transportation for members with long-term service and supports (LTSS) needs. The MCOP should contract with providers experienced in transporting members with LTSS needs. Characteristics of LTSS experienced providers include but are not limited to:

    i. The ability to help the member transfer between the pick-up location and the vehicle, to enter and exit the vehicle, and to transfer between the vehicle and the destination location safely;

    ii. Sensitivity to aging adults living with disabilities;

    iii. The ability to safely operate, secure, and transport a wheel chair or other assistive device;

    iv. Maintain vehicles equipped with fasteners to secure wheelchairs and prevent movement, and a stable access ramp or hydraulic lift; and

    v. The capacity to meet individual member needs when transporting.

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

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

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

Administrator at least one business day prior to the effective date of the change.

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

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

d. The MCOP shall identify members who are at risk for harm, loss, or injury during any potential natural, technological, or manmade disaster. The MCOP shall ensure every member who is technology and/or service dependent, with no known reasonable means to access services, is known and documented as part of the plan's Comprehensive Disaster/Emergency Response Plan. For these members, the MCOP shall develop an individual-level plan with the member when appropriate. The MCOP shall ensure staff, including care managers, are prepared to respond to and implement the plans in the event of an emergency or disaster. The member-level plan shall:

   i. Include a provision for the continuation of critical services appropriate for the member's needs in the event of a disaster;

   ii. Identify how and when the plan will be activated;

   iii. Be documented in the member record maintained by the MCOP; and

   iv. Be provided to the member.

21. **Member Rights.** The MCOP shall comply with 42 CFR 438.100, OAC rule 5160-26-08.3, and any applicable federal and state laws that pertain to member rights and ensure its staff adhere to such laws when furnishing services to its members. The MCOP 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.

22. **Cultural Competency and Communication Needs.** The MCOP is responsible for promoting the delivery of services in a culturally competent manner, as defined by the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://www.thinkculturalhealth.hhs.gov) to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identify. The MCOP shall make oral interpreter services for all languages available free of charge to all members and eligible individuals pursuant to 42 CFR 438.10(d)(4). The MCOP shall comply with the requirements specified in Section 2.12 of the Three-Way for member communication standards and shall comply with OAC rules 5160-58-01.1, 5160-26-03.1, 5160-26-05, and 5160-26-05.1 for providing assistance to LEP members and eligible individuals. In addition, the MCOP

shall provide written translations of certain MCOP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

a. If ODM identifies prevalent non-English languages in the MCOP's service area, the MCOP, as specified by ODM, shall translate marketing and member materials into the primary languages of those groups. The MCOP shall make these marketing and member materials available to eligible individuals free of charge.

b. The MCOP shall utilize a centralized database which records the special communication needs of all MCOP members (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment) and the provision of related services (i.e., MCOP materials in alternate format, oral interpretation, oral translation services, written translations of MCOP materials, and sign language services). This database shall include all MCOP member primary language information (PLI) as well as all other special communication needs information for MCOP members, as indicated above, when identified by any source including but not limited to ODM, the Hotline, MCOP staff, providers, and members. This centralized database shall be readily available to MCOP staff and be used in coordinating communication and services to members, including the selection of a primary care provider (PCP) who speaks the primary language of an LEP member, when such a provider is available.

c. The MCOP shall share specific communication needs information with its providers (e.g., PCPs, Pharmacy Benefit Managers [PBM], and Third-Party Administrators [TPAs]), as applicable.

d. The MCOP shall submit to ODM, upon request, detailed information regarding the MCOP'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 MCOP as well as those services reported to the MCOP which were arranged by the provider).

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

f. The MCOP shall participate in ODM's cultural competency initiatives.

g. The MCOP will use person-centered language in all communication with eligible individuals and members.

h. MCOP HIPAA privacy notices shall be translated into other languages pursuant to Marketing Guidance for Ohio Medicare-Medicaid Plans and Title VI of the Civil Rights Act. The MCOP shall also assess member primary languages and provide materials in other prevalent languages.

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

a. Informing members about Healthchek, the MCOP shall:

i. Inform each new member under the age of 21 about Healthchek services as prescribed by ODM and as specified by 42 CFR 441.56 within 5 calendar days of receipt of the 834C enrollment file. An MCOP may meet this requirement by including information with the new member materials specified in Appendix F. In addition, the MCOP 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. The MCOP's member handbooks shall be provided to members within the time frames specified in this appendix and shall include verbatim the model language developed by ODM. The model language at a minimum will include:

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

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

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

4. An explanation that providers may request prior authorization for:

b. Coverage of services that have limitations; and/or

c. Services not covered for members age 21 and older if the services are medically necessary EPSDT services.

iii. Provide the above Healthchek information on the MCOP's member website specified in this appendix.

iv. Deliver Healthchek information as provided, or as approved, by ODM to the MCOP's members at the following intervals:

1. January of each calendar year; and

2. In July for members from age 18 to under 21.

v. Use the mailing templates provided by ODM not to exceed two 8x11 pages for each mailing with most mailings being one page or less in length. The MCOP shall populate the materials with appropriate Healthchek information as required (e. g. type of service,

rendering provider, date of service, and age of member on the date of service).

b. Informing members about Pregnancy Related Services (PRS), the MCOP shall:

i. Upon the identification of a member as pregnant, the MCOP shall deliver to the member within 5 calendar days a PRS form as designated by ODM.

ii. The MCOP may be required to communicate with the member's local CDJFS agency any requests made by the member for county-coordinated services and supports (e.g. social services).

c. Informing providers about Healthchek, the MCOP shall:

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

1. The required components of a Healthchek exam as specified in OAC rule 5160-1-14;

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

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

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

ii. Provide the above information on the MCOP's provider website as specified in this appendix.

d. An MCOP shall maintain documentation to verify members and providers were informed of Healthchek and PRS as specified by ODM.

24. **Advance Directives.** All MCOPs shall comply with the advance directives requirements specified in 42 CFR 422.128. At a minimum, the MCOP shall:

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

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

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

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

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

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

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

ii. Provides for education of staff concerning the MCOP'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 each 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.

25. **Call Center Standards.** In addition to Sections 2.9.2 through 2.9.4 of the Three-Way, the MCOP shall:

a. Notify ODM of any hours of operation of the member services lines outside the required days and times as specified in Section 2.9.2 of the Three-Way.

b. Ensure access to medical advice, behavioral health crisis, and care management support services through centralized toll-free 24 hour, 7 days a week (24/7) call-in systems available nationwide. The 24/7 call-in systems listed in this section shall be staffed by appropriately qualified medical and behavioral health professionals whose scope of practice and licensure permits them to perform the required functions associated with the services. The MCOP shall ensure an appropriately qualified health professional is the caller's first point of live contact to answer the call, triage the issue, and determine an immediate course of action (e.g., warm transfer to care manager or local behavioral health crisis services, provide intervention, and offer medical advice). The MCOP may not require members to contact their PCP or any other entity prior to contacting the 24/7 call in systems for advice or direction concerning emergency or after-hours services. Only one auto-prompt can be used to get the caller to the live contact.

i. **Medical Advice Services**. For the purpose of meeting the staffing requirement for medical advice, appropriately qualified medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs).

ii. **Care Management Support Services**. For the purposes of meeting the staffing requirement for care management support services, the calls shall be answered and/or forwarded to the member's care manager or other team members designated to act on behalf of the care manager. The MCOP shall ensure if a care manager designee is used, the requirements in Section 2.5.3.3.3.4 of the Three-Way are met.

c. Maintain a log for the 24/7 call-in systems which shall be accessible by the MCOP and shall include at a minimum:

i. Identification of the member;

ii. Date and time of call;

iii. The reason for and disposition of the call;

iv. PCP or another provider if contacted by the MCOP; and

v. Name and title of person taking the call.

d. Have services available to assist:

i. Hearing impaired members; and

ii. Limited English Proficiency (LEP) members in the primary language of the member.

e. Have staff who are knowledgeable of the MyCare Ohio product line and have access to information pertaining to MyCare Ohio membership (e.g., membership status, benefits, provider network, care plans, etc.). The MCOP shall implement procedures to ensure emergent issues are identified and assigned the highest priority.

f. 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 for the medical advice, care management support, and the behavioral health crisis 24/7 toll-free call-in systems. If access to these call-in systems is facilitated through the member services line with auto-prompts to transfer the caller, the MCOP shall have a process to measure the above call center standards from the time of selecting the auto prompt. If the MCOP uses the member services line to answer the care management support services contacts (i.e., no auto prompt to transfer), then call center standards for the member services line specified in Section 2.9.2.2 of the Three-Way apply. ODM will inform the MCOP of any changes to these URAC call center standards.

g. Not meet the member services call center requirement 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, the MCOP is prohibited from publishing a delegated entity's general call center number.

h. At least semi-annually, self-report its monthly and semi-annual performance in meeting the URAC call center standards for the 24/7 hour toll-free call-in systems and the call center standards in Section 2.9.2.2 of the Three-Way for the member services line to ODM as specified. The MCOP shall report their July through December performance to ODM by January 10 and their January through June performance by July 10th. ODM reserves the right to require more frequent reporting by the MCOP if on-going monitoring (e.g., grievances, complaints, and contract administrator review) identifies an egregious access issue or consecutive months of noncompliance with URAC standards.

26. **Notification of Voluntary MCOP Membership.** To comply with the terms of the ODM State Plan Amendment for the managed care program, the MCOP shall inform Indians who are members of federally-recognized tribes that MCOP membership is voluntary. Except as permitted under 42 CFR 438.50(d)(2), this population is not required to select an MCOP in order to receive their Medicaid healthcare benefit. The MCOP shall inform these members of steps to take if they do not wish to be a member of an MCOP. Pursuant to 42 CFR 438.14, the MCOP shall provide access to an Indian healthcare provider to any enrolled Indian.

27. **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 the MCOP as a means of obtaining satisfactory assurance that the MCOP will appropriately safeguard all protected health information (PHI), which means information received from or on behalf of ODM that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 CFR 160.103, 45 CFR 164.501, and any amendments thereto.

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

    The MCOP 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 MCOP further acknowledges 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 MCOP, as a Business Associate agrees to comply with all of the following provisions:

    a. **Permitted Uses and Disclosures**. The MCOP 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 MCOP will 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 MCOP 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 MCOP has knowledge of or reasonably should have knowledge of under the circumstances.

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

e. **Incidental Costs.** The MCOP shall bear the sole expense of all costs to mitigate any harmful effect, of any breaches or security incidents which were caused by the MCOP, 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 MCOP, in compliance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2) as applicable, shall ensure all its agents and subcontractors that create, receive, maintain, or transmit PHI from or on behalf of the MCOP and/or ODM agree to have, in a written agreement, the same restrictions, conditions, and requirements that apply to the MCOP with respect to the use or disclosure of PHI.

g. **Accessibility of Information.** The MCOP shall make available to ODM information required by ODM 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 MCOP 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 MCOP receives a request for amendment directly from an individual, agent, or subcontractor, the MCOP shall notify ODM prior to making any such amendments. The MCOP's authority to amend information is explicitly limited to information created by the MCOP.

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

j. **Obligations of ODM**. When the MCOP is required to carry out an obligation of ODM under Subpart E of 45 CFR Part 164, the MCOP 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 MCOP 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 MCOP's obligations under this Article, ODM may immediately terminate this Agreement as set forth in the baseline of this Agreement. Termination of this Agreement will not affect any provision of this Agreement, which, by its wording or its nature, is intended to remain effective and to continue to operate after termination.

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

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

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

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

b. **Monthly Remittance Advice.** The HIPAA 820 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, and any other capitation payment/ recoupment.

c. **Enrollment and Monthly Capitation Reconciliation.** The MCOP shall maintain the integrity of its membership data through reconciliation of the daily HIPAA 834C files (Daily Benefit Enrollment and Maintenance) and the monthly HIPAA 834F file (Monthly Benefit Enrollment and Maintenance) transactions pursuant to ODM instructions. Discrepancies between the HIPAA 834C and 834F that have a negative impact on a member's access to care shall be reported to ODM within one business day. Reconciliation for any discrepancies between the HIPAA 834 and

HIPAA 820 is due and shall be submitted, as instructed by ODM, no later than 60 calendar days after the issuance of the HIPAA 820.

d. **Change in Member Circumstance.** In accordance with 42 CFR 438.608, the MCOP shall promptly notify ODM when it becomes aware that a member is deceased. The notification must be made following the submission guidelines, and in the format, prescribed by ODM.

e. **Institution for Mental Disease (IMD) Stays.** If a member aged 21 through 64 has an IMD stay exceeding 15 days per calendar month, ODM will recover a percentage of the plan's monthly capitation payment based on the total number of days the member was in the IMD.

f. **Reconciliation Request Format.** All reconciliation requests shall 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.

g. **Change in Enrollment During Hospital/Inpatient Facility Stay.** When an MCOP learns of a currently hospitalized member's intent to disenroll through the CCR or the HIPAA 834, the disenrolling MCOP shall notify the hospital/inpatient facility and treating providers as well as the enrolling MCOP, if applicable, of the change in enrollment. The disenrolling MCOP shall notify the inpatient facility that it will remain responsible for the inpatient facility charges through the date of discharge; and shall notify the treating providers that it will remain responsible for provider charges through the date of disenrollment. The disenrolling MCOP shall not request and/or require 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 MCOP shall notify the treating providers to work with the enrolling MCOP or ODM as applicable to facilitate the discharge, transfer and authorization of services as needed.

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

The MCOP shall inform the hospital/inpatient facility that the admitting/disenrolling MCOP remains responsible for the hospital/inpatient facility charges through the date of discharge. The enrolling MCOP shall work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.

When the MCOP learns that a new member who was previously on Medicaid fee-for-service was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the MCOP shall notify the hospital/inpatient facility and treating providers that the MCOP is responsible for the professional charges effective on the date of enrollment, and

shall work to ensure discharge planning provides continuity using MCOP-contracted or authorized providers.

h. **Just Cause Requests.** As specified in OAC rule 5160-58-02.1, the MCOP shall assist in resolving member-initiated just cause requests affecting membership.

i. **Eligible Individuals.** If an eligible individual, as defined in OAC rule 5160-58-01, contacts the MCOP, the MCOP shall provide any MCOP-specific managed care program information requested. The MCOP shall not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/transitioning health care services, the MCOP shall provide an assurance that all MCOPs shall cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.

j. **Pending Members.** If a pending member (an eligible individual subsequent to MCOP selection or assignment to an MCOP, but prior to his or her membership effective date) contacts the selected MCOP, the MCOP shall provide any membership information requested, including but not limited to explaining how to access services as an MCOP member and assistance in determining whether current services require prior authorization. The MCOP shall also ensure any care coordination (e.g., PCP selection, prescheduled services, and transition of services) information provided by the pending member is logged in the MCOP's system and forwarded to the appropriate MCOP staff for processing as required.

k. The MCOP 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 MCOP 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.

l. **Member Reimbursement.** Upon implementation of the amended rule, the MCOP shall follow OAC rule 5160-1-60.2 regarding direct reimbursement for out-of-pocket expenses incurred by members for Medicaid covered services during approved eligibility periods. If submitted properly by a member, the MCOP shall accept the ODM approved direct reimbursement packet and begin the direct reimbursement process. If the MCOP is the first contact a member makes regarding direct reimbursement, the MCOP shall begin the direct reimbursement process but may use their own process and documents.

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

31. **Coverage Requirements and Transition of Fee-For-Service (FFS) Members**. The MCOP shall pay claims for Medicaid covered services provided to members during retroactive enrollment periods. For services provided during retroactive enrollment periods, the MCOP may review only those services that require fee for service (FFS) prior authorization as documented in Appendix DD of OAC rule 5160-1-60, OAC rule 5160-9-12 (regarding pharmacy claims), and all other FFS regulations that set forth prior authorization policy. If the service was reviewed and approved by FFS, the MCOP shall also approve the service. The MCOP may also review to determine that home and community-based services were in accordance with

the pre-existing or current person-centered services plan.

a. Upon a member's initial enrollment in MyCare Ohio, the MCOP shall provide transition of Medicare and Medicaid services in accordance with the requirements specified in Section 2.5.4 of the Three-Way for both contracted and non-contracted providers. Non-contracted providers who provide services during the transition of Medicare and Medicaid services specified in Section 2.5.4 of the Three-Way shall be paid the Medicaid FFS rate. Prior to the end of any required transition period, the MCOP shall inform the member and non-contracted provider of the effective date of any transition to a contracted provider, during a meeting of the trans-disciplinary care team or by another method documented in the care plan.

b. During transition and/or when a member exhausts their Medicare lifetime benefit, unless the provider has expressly agreed to MyCare Ohio contract terms that include quality incentives and a different secondary claims payment rate, not including simple rate changes proposed by the MCOP, the MCOP shall pay Medicare secondary claims at a rate no less than the Medicaid FFS Part B methodology, set forth in OAC 5160-1-05.3, for contracted and non-contracted providers. Exemptions to the Part B Medicaid maximum policy shall be applied, in accordance with the OAC and other guidance issued by ODM. The Part C Medicaid maximum policy, set forth in OAC 5160-1-05.1, may only be applied for secondary claims on behalf of Medicaid only members enrolled with a Part C plan that is not the MCOP. The MCOP shall provide a method for enrollment of any non-contracted provider who is an enrolled provider with ODM for purposes of Medicaid payment of "crossover" claims pursuant to the CMCS-MMCO-CM Informational Bulletin of June 7, 2013.

c. The MCOP shall contract directly with the Fiscal Management Service (FMS) vendor selected by ODM to successfully transition and provide ongoing services for waiver consumers who have elected self-directed employer authority for authorized waiver services. The contract shall continue for the entire period of this Agreement. The MCOP shall submit a report each quarter to ODM using the format established by ODM to identify information about waiver members electing to self-direct their services.

d. Upon receipt, the MCOP shall be able to process and use the FFS historic utilization, prior authorization, and care management data files to assess pending members' risk stratification levels, to coordinate care and to adhere to transition requirements. When waiver service coordination data is omitted from the file transfer for a pending member enrolled in the FFS PASSPORT, or Assisted Living waiver, the MCOP shall reconcile the enrollment or data error with the PASSPORT Administrative Agency (PAA). When waiver service coordination data is omitted for pending members in the Ohio Home Care waiver, the MCOP shall notify its contract administrator to request enrollment reconciliation and/or data completion.

e. The MCOP shall make express arrangements to obtain current treatment plans from Ohio Department of Mental Health and Addiction Services (OhioMHAS) certified providers when a member's behavioral health services qualify for transition pursuant to Section 2.5.4 of the Three-Way.

f. The MCOP is responsible for implementing transition of care processes that prevent access problems for members who are transitioning from the FFS pharmacy benefit administrator to an

MCOP. The transition of care processes for prescribed drugs shall be consistent the requirements outlined in Medicare Part D.

32. **Transition of Care Requirements for MyCare Ohio Members Receiving Behavioral Health Services.** The MCOP is required to cover behavioral health services provided by a Community Behavioral Health Center (CBHC) to its members as directed by ODM.

    a. The MCOP shall follow Medicaid fee-for-service (FFS) behavioral health coverage policies, except that the MCOP may implement less restrictive policies than FFS.

    b. The MCOP shall maintain Medicaid FFS payment rates as a floor for behavioral health services when the MCOP provider contracts are based on FFS rates. This does not apply to Community Behavioral Health Center (CBHC) Laboratories. The requirements outlined in paragraph 31.b, above, are still applicable.

33. **Transition of Care Requirements for Members Receiving HCBS Waiver Services who Lose MyCare Ohio Eligibility**. As soon as the MCOP is notified by ODM via the 834C or 834F, CCR, and/or via another source of information (e.g., waiver service coordinator, member, provider), that a member who is receiving home and community based services (HCBS) waiver services that his or her enrollment is or may be terminated due to loss of MyCare Ohio eligibility, the MCOP shall identify the reason for loss of eligibility and timely assist the member, as appropriate, with maintenance of MyCare Ohio eligibility. Upon confirmation that MyCare Ohio eligibility will be terminated, during the last month of the individual's active membership, the MCOP shall instruct the appropriate local Area Agency on Aging (AAA) to end the MyCare Ohio waiver span in alignment with enrollment termination, and facilitate, as appropriate, referrals to programs (e.g., Medicaid waivers) and/or community resources that may assist the individual with continuation of long-term services and supports. The MCOP shall notify the member and all current waiver providers of the member's termination from MyCare Ohio, and as applicable, of any referral made to other Medicaid waivers. These referrals and notifications shall be completed prior to the end of the month of termination, and when this is not possible, as soon as possible thereafter. If the member is found eligible for a Medicaid waiver program, the MCOP shall provide the MyCare Ohio person-centered service plan and any identified service issues or follow-up necessary to successfully transfer care to the waiver case management agency.

34. **Transition of Care Requirements for Members Receiving HCBS Waiver Services who Move Outside of the MCOP's Service Area.** If the MCOP becomes aware through its member services, waiver service coordination or care management processes that a member receiving HCBS waiver services is changing residence to an address outside the MCOP service area, upon confirmation, the MCOP shall identify service providers and arrange for services that will align with the member's future HCBS waiver or MCOP enrollment, and inform the AAA of the proposed or actual change in address (for entry in the eligibility system). When the member is moving to another MyCare Ohio service area, the MCOP shall assist the member with contacting the Ohio Medicaid Consumer Hotline to select a new MCOP as soon as possible to avoid any break in MyCare Ohio enrollment.

35. **Transition of Care Requirements for Members who are Changing MyCare Ohio Plans**. When the MCOP is informed by ODM, or its designee, of a member who is changing to a different MCOP, the disenrolling MCOP shall share, at a minimum, the current assessment and care plan, including the person-centered

service plan, with the enrolling MCOP prior to the new enrollment effective date.

a. Upon notification from a member and/or provider of a need to continue services, the MCOP shall allow a member transitioning from another MCOP to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services. Upon notification from ODM that an individual will be switching to a different MCOP or managed care plan (MCP), the disenrolling MCOP shall provide specific information related to the disenrolling member to the enrolling plan as specified by ODM. The MCOP may prior authorize these services or assist the member to access services through a network provider when any of the following occur:

    i. The member's condition stabilizes and the MCOP can ensure no interruption to services;

    ii. The member chooses to change to a network provider;

    iii. The member's needs change to warrant a change in service; or

    iv. Quality concerns are identified with the provider.

b. The enrolling MCOP shall honor the disenrolling MCOP's prior authorization for all new members until the enrolling MCOP is able to conduct a medical necessity review. The MCOP shall honor prior authorizations and continue services with network and out-of-network providers as specified by ODM.

36. **Payment to Nursing Facility or HCBS Waiver Providers.** The MCOP shall ensure accurate claims payment to nursing facility (NF) and home and community-based services (HCBS) waiver providers by appropriately modifying payment pursuant to 5160-3-39.1 when a member has patient liability obligations, lump sum amounts and/or restricted Medicaid coverage periods (RMCP). Patient liability shall be applied as an offset against the amount Medicaid would otherwise reimburse for the claim. If the patient liability exceeds the amount Medicaid would reimburse, the claim shall be processed with a payment of zero dollars. The MCOP is prohibited from paying for NF services and LTSS during an RMCP. The MCOP shall utilize HIPAA compliant enrollment files for patient liability obligations and RMCPs.

37. **Patient Liability and Cost of Care Reconciliation**. Pursuant to the approved 1915(c) MyCare Ohio waiver, following a four-month claims run-out period, the MCOP shall provide monthly reconciliation reports, as designated by ODM, to each AAA documenting any month for which the waiver member's actual cost of HCBS waiver services is less than the member's patient liability amount for the same period. For all members except those using the Assisted Living Service, the report shall specify the actual payment amount of HCBS waiver services delivered and the patient liability amount for the applicable month. The report shall be submitted to the AAA no later than the 15th of the month. If no members meet the reporting criteria, the MCOP shall enter 'N/A' in the first row of all columns and submit as instructed.

38. **Waiver Enrollment.** For new enrollment on the MyCare waiver, the MCOP or its designee shall submit a level of care assessment request to the local Area Agency on Aging (AAA). Waiver eligibility approval and denial notices with hearing rights will be generated from the eligibility system designated by ODM. The

MCOP shall authorize waiver services in accordance with OAC 5160-58-01.1 and 5160-26-03.1.

39. **Health Information System Requirements.** The ability to develop and maintain information management systems capacity is crucial to successful plan performance. The MCOP shall demonstrate its ongoing capacity in this area by meeting several related specifications.

    a. **Health Information System.**

        i. As required by 42 CFR 438.242(a), the MCOP shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, and MCOP membership terminations for other than loss of Medicaid eligibility.

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

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

        iv. As required by 42 CFR 438.242(b)(4), the MCOP shall make all collected data available upon request by ODM or CMS.

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

            1. Before the MCOP may submit production files;

            2. When the MCOP changes the method or preparer of the electronic media; and/or

            3. When ODM determines the MCOP's data submissions have an unacceptably high error rate.

        vi. When the MCOP changes or modifies information systems involved in producing any type of electronically submitted files, either internally or by changing vendors, it is required to submit to ODM for review and approval a transition plan that includes the submission of test files in the ODM-specified formats. Once an acceptable test file is submitted to ODM, as determined solely by ODM, the MCOP can return to submitting production files. ODM will inform the MCOP in writing when a test file is acceptable. Once the MCOP's new or modified information system is operational, the MCOP will have up to 90 calendar days to submit an acceptable test file and an acceptable production file.

        vii. Submission of test files can start before the new or modified information system is in production. ODM reserves the right to verify the MCOP's capability to report elements in the minimum data set prior to executing the Agreement for the next contract period.

Sanctions for noncompliance with this requirement are specified in the Compliance Methodology document.

b. **Claims Adjudication and Payment Processing Requirements.**

i. **Timely Filing for Behavioral Health (BH) Claims.** The MCOP must accept claims for BH services described in OAC Chapter 5160-27 for at least 180 calendar days after the date of service and no longer than 365 calendar days after the date of service. An MCOP may negotiate timely filing requirements within these limitations through their contract with the BH provider.

ii. **Claim Adjudication.** The MCOP shall have the capacity to electronically accept and adjudicate all claims to final status (payment or denial). Information on claims submission procedures shall be provided to non-contracting providers within 30 calendar days of a request. The MCOP shall inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information shall be initiated by the MCOP and not only in response to provider requests. The MCOP shall have a sufficient number of provider service representatives who are knowledgeable of the MCOP's claims system.

iii. **Claim Status.** The MCOP shall notify providers who have submitted claims of claims status (paid denied, and all claims not in a final paid or denied status [hereinafter referred to as "pended/suspended"]) within one month of receipt by the MCOP or its designee. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly, or more frequent, basis. The MCOP provider portal shall allow for the availability of all remittance advices upon request and should be capable of elements such as the following submission, resubmission, and adjustment. If a provider and/or a provider's clearinghouse submits a HIPAA compliant 276 EDI transaction to the MCOP and/or the MCOP's clearinghouse, the MCOP/clearinghouse shall respond with a complete HIPAA compliant 277 EDI transaction within the required Council for Affordable Quality Healthcare, Inc. (CAQH) Committee on Operating Rules for Information Exchange (CORE) timeframes with the HIPAA compliant claim status category code(s) and claim status code(s) that will provide information on all denied, paid, or pended claims to the submitter.

iv. **Grouping Methodology.** When the MCOP uses a grouping methodology to pay inpatient and/or outpatient hospital claims, or ambulatory surgery center (ASC) claims, they are expected to utilize the same grouper software and version that ODM uses to process fee-for-service claims.

1. For inpatient hospital claims, the MCOP shall use the 3M All-Patient Refined Diagnosis Related Grouper (APR-DRG) and utilize the same version that ODM uses.

2. For outpatient hospital claims and ASC claims, the MCOP shall use the 3M Enhanced Ambulatory Patient Grouping (EAPG) and utilize the same version

that ODM uses.

v. **Electronic Visit Verification (EVV).** The MCOP shall utilize the ODM-established EVV system for the following services: Private Duty Nursing; State Plan Home Health Aide; State Plan Home Health Nursing; RN Assessment, Waiver Nursing; Waiver Personal Care Aide; Waiver Home Care Attendant. The MCOP will use data collected from the EVV data collection system data to validate all claims against EVV data (100% review) during the claim adjudication process. The MCOP shall inform providers of the use of the EVV data collection system and how the data will be utilized by the MCOP. The MCOP shall also provide assistance on utilization of the data collection system, as appropriate, to individuals receiving services, direct care workers, and providers. During the Pay and Post period of EVV, the MCOP shall submit a monthly report of all EVV related claims that would have denied as specified by ODM. Upon full implementation of EVV, the MCOP shall submit a monthly report of all EVV related denied claims as specified by ODM.

vi. Except in the event of fraud or abuse, the MCOP is prohibited from recovering back or adjusting any payments beyond two years from the date of payment of the claim due to the MCOP member's retroactive termination of coverage from the MCOP, unless the MCOP is required to do so by CMS, ODM, or applicable state or federal law and regulation.

vii. **Claims Payment Systemic Errors (CPSEs).** For the purpose of this appendix, a CPSE is defined as the MCOP's claims adjudication, either electronic or manual, incorrectly underpaying, overpaying, or denying claims that impact five or more providers. ODM reserves the right to request and receive additional information for ODM to classify an issue as a CPSE.

1. The MCOP shall have policies and procedures implemented to identify, communicate, and correct CPSEs.

2. The MCOP shall submit the CPSEs to ODM based on the ODM calendar of submissions schedule.

3. The MCOP shall follow all CPSE template instructions and guidelines.

4. The MCOP shall inform ODM monthly of the status of CPSEs as follows:

    a. The detailed description and scope of any identified CPSEs including potential CPSEs;

    b. The date the CPSE was first identified;

    c. The type of providers impacted;

d. The number of providers impacted;

e. The date(s) and method(s) of provider notification of the CPSE;

f. The projected timeline for fixing the CPSE, including any UAT testing;

g. The date(s) for corrected payment/adjustment to providers.

3. **Policies and Procedures.** The MCOP shall submit their policies and procedures to ODM for prior approval and include, at a minimum:

a. The use of input from internal and/or external sources to identify a CPSE, including but not limited to, claims processing activities, configuration checks, user acceptance testing (UAT) activities, provider complaints/inquiries, audits, and quality initiative activities;

b. The identification of issues impacting smaller provider types (e.g., independent providers, etc.);

c. A description of the process, including timelines, to escalate from initial intake to definition of the error, for example, how the MCOP tracks if internal or external sources have identified that an issue has occurred;

d. A description of the process to inform ODM at least monthly of the status of CPSEs as specified above;

e. A communication strategy to timely notify applicable providers of a CPSE identification, how claims will be re-adjudicated, the expected date(s) for corrected payment/adjustment, and for providers to contact the MCOP regarding re-adjudicated claims from the fix;

f. A description of the process and timeline to determine the root cause of the issue including UAT, time frame to re-adjudicate claims, and address any provider disputes regarding corrected payments/adjustments.

viii. The MCOP shall correct errors in provider payments that do not meet the definition of claims payment systematic errors per this appendix within 60 calendar days from the date of identification of the error.

ix. The MCOP shall load rate changes into applicable systems by either the rate change implementation date or within 30 calendar days of being notified by ODM of the change, whichever date is later.

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

xi. The MCOP is required to give a 30-calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payments processing.

xii. **ProviderWeb Portal Complaints.** The MCOP should check the ProviderWeb portal (hereinafter referred to as HealthTrack) complaint inbox daily for updates and new complaints assigned to them.

a. The MCOP shall acknowledge receipt of a HealthTrack complaint within 5 business days of the complaint's submission by:

i. Outreaching to the provider through an in-person visit, a phone call, or an email. If attempting to make contact via phone and the person is unavailable, a voicemail must be left. Outreach must include that the complaint was received and that the MCOP will respond by the assigned due date; and

ii. Documenting the MCOP's contact with the provider in HealthTrack.

b. The MCOP shall perform internal research, contact the provider, and present its findings to the provider.

i. Provider Contact shall include:

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

2. The assigned provider representative's contact information;

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

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

ii. The MCOP shall document the following in HealthTrack by the assigned due date:

1. The date(s) contact was made with the provider (a future date of contact will not be accepted);

2. The method(s) of contact;

3. The name of the individual(s) contacted;

4. The findings shared with the provider; and

5. The policies and procedures to support the findings.

iii. If the MCOP requires additional time to research a provider complaint, the MCOP shall:

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

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

iv. ODM reserves the right to shorten the length of time the MCOP is allotted to address a complaint. ODM will enter a comment in HealthTrack advising the MCOP that the due date has been shortened.

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

i. The MCOP shall comply with all applicable provisions of HIPAA including EDI standards for code sets and the following electronic transactions:

1. Health care claims;

2. Health care claim status request and response;

3. Health care payment and remittance status;

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

iii. The MCOP shall have the capacity to accept the following transactions from ODM consistent with EDI processing specifications in the transaction implementation guides and in conformance with the 820 and 834 Transaction Companion Guides issued by ODM:

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

2. ASC X12 834 - Benefit Enrollment and Maintenance.

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

v. The capacity of the MCOP and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions in compliance with standards and effective dates mandated by HIPAA shall be demonstrated, to the satisfaction of ODM.

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

vii. Noncompliance with the EDI and claims adjudication requirements will result in the imposition of sanctions, as outlined in the Compliance Methodology document.

d. **Encounter Data Submission Requirements.**

i. The MCOP shall collect data on services furnished to members through a claims system and shall report encounter data electronically to ODM as specified in Appendix L.

ii. The MCOP shall have the capability to report all elements in the Minimum Data Set as set forth in the ODM Encounter Data Specifications and shall submit a test file in the ODM-specified medium in the required formats prior to contracting or prior to an information systems replacement or update. Acceptance testing of encounter data is required as specified in Section 43 of this appendix.

iii. A certification letter shall accompany the submission of an encounter data file in the ODM-specified medium. The certification letter shall be signed by the MCOP'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 MCOP's CEO or CFO.

e. The MCOP shall submit files as specified in the *MyCare Ohio Nursing Facility Specifications and Submission Instructions* within timeframes specified by ODM. In addition, the MCOP shall collect and submit to ODM upon request the actual nursing facility admission date (any payer) of each member for whom a 100-day threshold was submitted. Pursuant to 42 CFR 438.606, the CEO or CFO remains responsible for certification regardless of delegated signee.

f. **IDSS Data Submission and Audit Report Requirements.** In accordance with 42 CFR 438.606, the MCOP shall submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODM. The MCOP shall also submit to ODM a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODM. Each data certification letter is due to ODM on the same day the respective HEDIS IDSS data/FAR is to be submitted. For complete instructions on submitting the data certification letters, see ODM Methodology for MCOP Self-Reported,

Audited HEDIS Results.

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

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

ii. Review the completed ISCA and accompanying documents;

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

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

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

vi. Examine MCOP processes for data transfers;

vii. If the MCOP has a data warehouse, evaluate its structure and reporting capabilities;

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

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

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

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

42. In the event of an insolvency of the MCOP, the MCOP, as directed by ODM, shall cover the continued provision of services to members until the end of the month in which insolvency has occurred, and shall also continue the coverage of inpatient services until the date of discharge for a member who is institutionalized when insolvency occurs.

43. **Information Required for MCOP Provider Websites.**

a. The MCOP shall have a secure internet-based website for contracting providers through which providers can confirm a member's enrollment and through which providers can submit and receive responses to prior authorization requests (an email process is an acceptable substitute if the website includes the MCOP's email address for such submissions). The provider website shall contain accurate enrollment information for all members including whether a member is a dual benefits member or a Medicaid-only member, specifically using those terms.

b. The MCOP provider website shall include, at a minimum, the following information which shall be accessible to providers and the general public without any log-in restrictions:

i. MCOP contact information, including the MCOP's designated contact for provider issues;

ii. A listing of the counties the MCOP serves unless the MCOP serves the entire state in which case the MCOP may indicate it services the entire state;

iii. The MCOP's provider manual including the MCOP's claims submission process, as well as a list of services requiring PA, recent newsletters, and announcements;

iv. The MCOP'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 MCOP;

v. The MCOP's internet provider directory as referenced in Appendix H; and

vi. The MCOP's PDL, including an explanation of the list and identification of any preferred drugs that require PA, the MCOP'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 MCOP's policy for coverage of generic versus brand name drugs. The MCOP shall publish a 30-calendar day's advance notice of changes to the MCOP's PDL.

vii. A notice of changes to the MCOP's list of drugs requiring prior authorization or any other service of device requiring prior authorization via their website 30 calendar days in advance. In addition, 30 calendar days prior to all PA requirement changes, the MCOP shall notify providers, via email or standard mail, the specific location of prior authorization change information on the website, pursuant to ORC Section 5160.34(B)(9-10).

viii. Documentation specifics for PA completion and details about Medicaid programs and their services requiring PA (e.g., drugs, devices) pursuant to ORC Section 5160.34(B)(11).

ix. In-office access to their preferred drug and prior authorization lists to prescribers via the availability of at least one hand-held software application.

x. All Healthchek information as specified in this appendix.

xi. Prominent, easily understood information on its website for members and providers regarding the optimization of pregnancy outcomes. This shall include information for providers, trusted messengers (e.g., community health workers), and patients about the prevention of preterm birth through the use of progesterone treatment by linking to the Ohio Perinatal Quality Collaborative's information about progesterone best practices at (https://opqc.net/projects/progesterone) and the Ohio Department of Health's progesterone-messaging toolkit located at (GoWhenYouKnow.org). The MCP shall include a link to the official ODM notification of pregnancy and risk assessment form (PRAF 2.0) located at https://medicaid.ohio.gov/Provider/PRAF with a statement encouraging MCP-contracted providers to complete and submit the form to assist pregnant women in maintaining Medicaid eligibility and connecting to needed services and supports (e.g., home visiting).

xii. Any additional information that ODM may require the MCOP to include on the provider website as needed.

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

45. **Coordination of Benefits Agreement (COBA).** In compliance with 42 CFR 438.3(t), the MCOP shall maintain and update their COBA Attachment to the ODM COBA Agreement with CMS' Benefits Coordination and Recovery Center (BCRC). The MCOP shall provide ODM with a COBA communication contact to coordinate communication and attend meetings with the BCRC and ODM. The MCOP shall also provide ODM with a technical contact to answer questions about the file transfer process and attend technical meetings as required to successfully test and administer the COBA process. Technical and Communication contacts are required to attend a monthly conference call for Group 2 titled: Medicaid/Fiscal Agents, hosted by the BCRC.

    a. The MCOP shall initiate file testing with the BCRC upon request from ODM and/or the BCRC. The MCOP shall inform ODM in writing upon successful conclusion of testing and readiness for production.

    b. Production files shall be submitted on the same schedule as ODM, the 2nd and 15th of each calendar month, in accordance with the file specifications issued by the BCRC, and shall include all enrollment spans added or deleted on the MCOP's 834 C and F files.

    c. The MCOP shall submit a monthly status report ODM by the 25th of each month, documenting production file status and any issues affecting testing and/or production. Production status reports shall contain an attestation that the file submissions to the BCRC were accurate, complete, and timely; the information submission and receipt of data were made in accordance with 45 CFR 164.502 and 45 CFR 164.504(e); and all protected health information was safeguarded appropriately. If there was a problem with any production file, the status report

shall document the reason for the error

46. Unless otherwise indicated, MCOP submissions with due dates fall on a weekend or holiday are due the next business day.

47. **Transfer of PHI from ODM Incident Management and Provider Oversight Contractors.** ODM contracts with a vendor to serve as the investigative entity and provider oversight vendor for ODM with respect to the investigation of incidents and to conduct provider oversight activities for certain Ohio Medicaid waiver and Specialized Recovery Services (SRS) program enrollees. The MCOP shall report and address all incidents for MyCare Ohio waiver and SRS program members in accordance with OAC rule 5160-44-05 via entry into the ODM Incident Management System. For each critical incident the MCOP shall enter a prevention plan into the IMS no later than 7 calendar days after being notified that the incident was substantiated. The MCOP shall close each "reportable" incident (identified in 5160-44-05; paragraph F) no later than 30 calendar days after submission of the incident into IMS. The MCOP shall report, no later than 24 hours of discovering the occurrence, to the ODM provider oversight vendor via the ODM Incident Management System and/or to ODA via the ODA-established mailbox (unless otherwise directed), any discovery of provider non-compliance with the provider conditions of participation outlined in OAC rule 5160-45-10 or 173-39-02, according to the entity that certified/approved the waiver provider.

    a. ODM has instructed the incident management vendor to accept and provide data to the MCOPs. The data to be transferred includes Protected Health Information (PHI) as defined in 45 C.F.R. Parts 160 and 164 ("Privacy Regulations").

    b. ODM and the MCOP are covered entities under HIPAA. Both the incident management vendor and the MCOP are Business Associates of ODM, as defined in the Privacy Regulations, and have executed Business Associate Agreements directly with ODM in accordance with HIPAA and the Privacy Regulations.

    c. With each critical incident reported, the MCOP shall also provide waiver member case notes (at least one month prior to the incident; and at least three months prior to an unexplained death), the most recent assessment, and the service plan in effect at the time of the incident. If plans are unable to submit these documents at the time the incident report is made, the MCOP shall upload them to the ODM incident management system no later than three business days after submitting the incident report to the incident management system. For the purpose of investigating critical incidents set forth in OAC rule 5160-44-05, the incident management vendor, ODM, or the incident management vendor and ODM jointly, may ask for additional information, records, data, documentation, prevention plans, etc. as deemed necessary by ODM or the incident management vendor to complete the investigation or prevention plan evaluation. If necessary to ensure the immediate health and welfare of the members, the request may be made before the three business day standard. The MCOP shall respond promptly to the incident management vendor and/or ODM requests for documentation (to ensure incident investigations may be completed within the required timeframe established in OAC rule 5160-44-05 or as otherwise instructed by ODM). The MCOP and incident management vendor shall exchange such information as necessary for the MCOP to meet both entities' contractual duties under this Agreement. The MCOP shall be held to the requirements set forth in the ODM MyCare Ohio Waiver Incident Escalation Procedure (revised 2019). If ODM learns

the MCOP has not promptly submitted required materials, ODM may impose a sanction on the MCOP in accordance with Appendix N.

d. For each Provider Occurrence reported into the IMS, the MCOP shall submit the following documentation: waiver member case notes (at least one month prior to the occurrence); The waiver service plan in effect at the time of the occurrence; Any documents the MCOP has obtained related to the occurrence; Any historical incident information the MCOP has regarding issues involving the provider related to the occurrence. The Provider Oversight vendor may request more documentation, or other documentation pertinent to their review of the occurrence and if so, the MCOP shall provide it.

e. ODM represents and warrants that separate from this Agreement, a Business Associate agreement fully compliant with the Health Insurance Portability and Accountability Act of 1996 and the HITECH provisions of the American Recovery and Reinvestment Act of 2009 (collectively "HIPAA") and with 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations") has been executed by the incident management vendor and is currently effective and will remain in effect for the Term of this Agreement.

48. Pursuant to ORC Section 5167.14, the MCOP shall enter into a data security agreement with the State of Ohio's Board of Pharmacy that governs the MCOP's use of the Board's drug database established and maintained under ORC Section 4729.75.

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

50. **Conducting Business Outside the United States.**

a. The MCOP shall comply with Executive Order 2019-12D. A copy of Executive Order 2019-12D can be found at https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/2019-12d. This Executive Order prohibits the use of public funds to purchase services 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 MCOP shall not transfer PHI to any location outside the United States or its territories.

b. Pursuant to 42 CFR 438.602, no MCOP claim paid to any provider, out-of-network provider, subcontractor, or financial institution located outside of the United States is considered in capitation rates. In addition, no contracting ODM MCOP shall be located outside the United States or its territories.

51. **National Committee for Quality Assurance (NCQA) Requirements.** The MCOP shall hold and maintain accreditation by the NCQA for the Medicare or Medicaid line of business as specified in 2.2.4 of the Three-Way, and shall achieve and/or maintain an Excellent, Commendable or Accredited status. If the MCOP receives a provision or denied status from NCQA, the MCOP will be subject to sanctions as noted

in Appendix N. Compliance will be assessed annually based on the MCOP's accreditation status posted on the NCQA 'Report Cards' webpage as of November 1st of each year.

Upon ODM's request, the MCOP shall provide any and all documents related to accreditation.

52. **Advisory Councils.** In addition to the requirements listed in Section 2.9.5 of the Three-Way, the MCOP shall report the following to ODM on the 15th of July, October, January, and April of each calendar year:

    a. List of attending members during the prior quarter for each regional Consumer Advisory Board;

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

    c. The MCOP's method for determining the Board's membership reflects the diversity of its enrolled population and includes members with disabilities.

53. **Home and Community Based Services (HCBS) Waiver Requirements.** For reconciliation of existing waiver enrollees to the MyCare waiver, the MCOP shall report to ODM any MyCare member for whom an active waiver span is indicated on the 834 file that documents any waiver but the MyCare Ohio waiver. The MCOP shall submit monthly waiver enrollment information to ODM and shall participate in an annual waiver enrollment reconciliation process at the end of each waiver year.

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

    a. The ACA requires the MCOP 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 MCOP in the preceding calendar year (as applicable to each relevant year, the "Data Year"), and continuing similarly in each successive year.

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

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

1. The amount of the Annual Fee attributable to this Agreement;

2. The corporate income tax liability, if any, the MCOP incurs as a result of receiving ODM's payment for the amount of the Annual Fee attributable to this Agreement; and

3. Any Ohio state and local Sales and Use taxes and Health Insuring Corporation taxes.

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

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

1. Total premiums reported on IRS Form 8963;

2. Ohio Medicaid-specific premiums included in the premiums reported on Form 8963;

3. The amount of the Annual Fee as determined by the IRS; and

4. The corporate income tax rate applicable to the year of such payments.

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

This provision shall survive the termination of the Agreement.

55. The MCOP shall have a listing of available independent providers and assist a member in finding an independent provider when requested by the member.

56. **MCOP Portfolio Expansion.** The MCOP shall immediately report to ODM all arrangements wherein services or contracts may overlap with Medicaid plans when seeking to expand its portfolio through contracts with other entities.

57. **Sub-contractual Relationships and Delegation.** If the MCOP's responsibilities or services under this Agreement are delegated to any first tier, downstream, or related entity (collectively, the other entities are "FDR" and any such agreement with an FDR is the "FDR agreement"), the MCOP shall ensure it has a written agreement with the FDR to perform administrative services as defined below on the MCOP's behalf.

    a. Parties to administrative services arrangements are defined as:

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

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

iii. Related Entity – any party related to the MCOP by common ownership or control, and under an oral or written arrangement performs some of the administrative services under the MCOP's contract with ODM.

b. The following provisions apply and shall be followed before any FDR agreement is executed or renewed:

i. At least 30 days prior to the MCOP executing any FDR agreement (hereinafter referred to as "the FDR agreement review period"), the MCOP shall provide the proposed FDR agreement to ODM for review. ODM, in its sole discretion, can agree to a shorter FDR agreement review period.

ii. During the FDR agreement review period, ODM has the right to ask questions and request information from the MCOP and the FDR about any provisions in the proposed FDR agreement.

iii. The MCOP and the FDR shall promptly respond to and provide complete answers and information to ODM in response to ODM's questions and requests.

iv. ODM has the right and authority to designate the FDR agreement, or any portion thereof, as incompatible with this Agreement, incompatible with ODM's state plan amendment (SPA), incompatible with federal, state, or local regulations and laws, or unacceptable to ODM for any other reason, without limitation. If ODM determines that any provision of the proposed FDR agreement (or the FDR agreement as a whole) is unacceptable or incompatible as state above, the MCOP shall either revise the proposed FDR agreement to ODM's satisfaction or otherwise the MCOP will seek a new proposed FDR agreement. The new proposed FDR agreement, and any thereafter, will be subject to an FDR agreement review period.

v. The MCOP shall not execute the proposed FDR agreement until ODM has stated in writing that the FDR agreement is acceptable. ODM's approval does not need to be made within 30 days of receiving the proposed FDR agreement.

vi. In addition to the provision above in subsections i. through v., ODM also has the right to forego the FDR agreement review period for any proposed FDR agreement. In such cases, ODM shall notify the MCOP in writing that the MCOP can execute the proposed FDR agreement without ODM conducting a review.

c. ODM shall have the right to review the terms of any FDR arrangement upon request, and such arrangements shall include terms requiring the FDR to grant ODM access to documents and other records relevant to the FDR's performance thereunder.

d. Unless otherwise specified by ODM, administrative services include: care management, marketing, utilization management, quality improvement, enrollment, disenrollment, membership functions, claims administration, licensing and credentialing, provider network management, and coordination of benefits.

e. Before the MCOP enters into an arrangement with an FDR to perform an administrative function not listed above that could impact a member's health, safety, welfare or access to Medicaid covered services, the MCOP shall contact ODM to request a determination of whether or not the function should be included as an administrative service that complies with the provisions listed herein.

f. If applicable, the MCOP and FDR shall narrowly designate portions of any FDR agreement as proprietary information. Portions of the FDR agreement designated as proprietary information shall be limited to the following:

    i. Portions of the FDR agreement that meet the definition of proprietary information in Article VII.B of this Agreement; and

    ii. Portions of the FDR agreement that consist of unique business or pricing structures that a competitor may or would likely use to gain an unfair market advantage over the FDR.

    Proprietary designations in every FDR agreement shall be limited consistent with the foregoing. Every portion of an FDR agreement that is not designated as proprietary will be deemed to be a public record.

g. All FDR agreements shall include the following enforceable provisions:

    i. A description of the administrative services to be provided by the FDR and any requirements for the FDR to report information to the MCOP.

    ii. The beginning date and expiration date or automatic renewal clause for the arrangement, as well as applicable methods of extension, renegotiation, and termination.

    iii. Identification of the service area and Medicaid population, either "dual" or "dual and non-dual" the FDR will serve.

    iv. A provision stating the FDR shall release to the MCOP and ODM any information necessary for the MCOP to perform any of its obligations under the MCOP's provider agreement with ODM, including but not limited to compliance with reporting and quality assurance requirements.

v. A provision that the FDR's applicable facilities and records will be open to inspection by the MCOP, ODM, its designee or other entities as specified by the MyCare Ohio Provider Agreement or in OAC rule.

vi. A provision that the agreement is governed by, and construed in accordance with, all applicable state or federal laws, regulations, and contractual obligations of the MCOP. The arrangement shall be automatically amended to conform to any changes in laws, regulations, and contractual obligations without the necessity for written amendment.

vii. A provision that Medicaid eligible individuals and ODM are not liable for any cost, payment, copayment, cost-sharing, down payment, or similar charge, refundable or otherwise for services performed, including in the event the FDR or MCOP cannot or will not pay for the administrative services. This provision does not prohibit waiver entities from collecting patient liability payments from MCOP members as specified in OAC rule 5160:1-6-07.1.

viii. The procedures to be employed upon the ending, nonrenewal or termination of the arrangement including at a minimum to promptly supply any documentation necessary for the settlement of any outstanding claims or services.

ix. A provision that the FDR will abide by the MCOP's written policies regarding the False Claims Act and the detection and prevention of fraud, waste, and abuse.

x. A provision that the FDR, and all employees of the FDR, are subject to the applicable provider qualifications in OAC rule 5160-26-05.

xi. For an FDR providing administrative services resulting in direct contact with a Medicaid eligible individual, a provision that the FDR will identify, and where indicated, arrange pursuant to the mutually agreed upon policies and procedures between the MCOP and FDR for the following at no cost to the individual or ODM:

    1. Sign language services; and

    2. Oral interpretation and oral translation services.

xii. For an FDR providing licensing and credentialing services of medical providers a provision that:

    1. The credentials of medical professionals affiliated with the party or parties will be reviewed by the MCOP; or

    2. The credentialing process will be reviewed and approved by the MCOP and the MCOP will audit the credentialing process on an ongoing basis.

xiii. For an FDR providing administrative services resulting in the selection of providers, a provision that the MCOP retains the right to approve, suspend, or terminate any such

selection.

xiv. A provision that permits ODM or the MCOP to seek revocation or other remedies, as applicable, if ODM or the MCOP determines the FDR has not performed satisfactorily or the arrangement is not in the best interest of the MCOP's members.

xv. A provision stating that all provisions on an FDR agreement must conform to and be consistent with all of the provisions of the MyCare Ohio Provider Agreement.

xvi. A provision that all of the provisions applicable to the FDR of the MyCare Ohio Provider Agreement supersede all applicable provisions in an FDR agreement. If a provision in an FDR agreement contradicts or is incompatible with any applicable provision in the MyCare Ohio Provider Agreement, the applicable provision in the FDR agreement is rendered null and void, unenforceable, and without effect.

xvii. A provision stating that all FDRs shall fully assist and cooperate with the MCOP in fulfilling the MCOP's obligations under the MyCare Ohio Provider Agreement.

xviii. A provision that allows the MCOP to obtain and gather data, documents, and information from FDRs for the purpose of Auditor of State audits.

h. The MCOP is ultimately responsible for meeting all contractual obligations under the MCOP's provider agreement with ODM. The MCOP shall:

i. Ensure the performance of FDR is monitored on an ongoing basis to identify any deficiencies or areas for improvement;

ii. Impose corrective action on the FDR as necessary; and

iii. Maintain policies and procedures to ensure there is no disruption in meeting their contractual obligations to ODM, if the FDR or MCOP terminates the arrangement between the FDR and the MCOP.

i. Unless otherwise specified by ODM, all information required to be submitted to ODM shall be submitted directly by the MCOP.

j. Information regarding changes to or termination of FDR arrangements shall be reported to ODM no less than 15 calendar days prior to it taking effect.

k. Delegation requirements do not apply to care management arrangements between the MCOP and a Recovery Management entity as cited in Appendix K.

l. In accordance with 42 CFR 438.602, the MCOP shall post on its website the name and title of individuals included in 42 CFR 438.604(a)(6). For the purposes of this requirement, the term "subcontractor" is defined as any individual or entity that has a contract with the MCOP that relates directly or indirectly to the performance of the MCOP's obligations under this Agreement, not including a network provider.

58. **Appeals and Grievances.** The MCOP shall have written policies and procedures for an appeal and grievance system for members, in compliance with the requirements of OAC rule 5160-58-08.4, 42 CFR 422.564, and 42 C.F.R. 438 Subpart F, and shall include the participation of individuals authorized by the MCOP to require corrective action. The MCOP is prohibited from delegating the appeal or grievance process to another entity unless approved by ODM. These policies and procedures shall include a process by which members may file grievances and appeals with the MCOP, and a process by which members may access the state's fair hearing system through the Ohio Department of Job and Family Services (ODJFS) Bureau of State Hearings (BSH).

    a. **State Hearing Process**. The MCOP shall develop and implement written policies and procedures that ensure the MCOP's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code. Upon request, the MCOP's state hearing policies and procedures shall be made available for review by ODM. When the MCOP is notified by BSH that a member has requested a state hearing, the MCOP shall review the state hearing request and within two business days of receipt of the BSH notice, confirm via email to State_Hearings_Scheduling@jfs.ohio.gov one of the following:

        i. The MCOP has no record that the member has requested a plan appeal pertaining to the state hearing request;

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

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

        iv. The MCOP has not yet made a decision on the appeal request pertaining to the state hearing request and identify the date the MCOP received the appeal request and the date the MCOP is currently required to decide an appeal resolution.

    Unless the timeframe for a member to file an appeal to the MCOP is exhausted in accordance with OAC 5160-58-08.4, if the MCOP confirms to BSH that there is no record of the member requesting a plan appeal, the MCOP shall attempt to contact the member to initiate the plan appeal process.

    b. **Logging and Reporting of Appeals and Grievances**. The MCOP shall maintain records of all appeals and grievances, including resolutions, for a period of ten years. Upon request, the records shall be made available to ODM and the Medicaid Fraud Control Unit.

        i. The record of each grievance or appeal shall contain, at a minimum:

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

2. The date the appeal or grievance was received;

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

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

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

6. If applicable, the date of the resolution.

ii. The MCOP shall identify a key staff person responsible for the logging and reporting of appeals and grievances and ensuring the grievance and appeals system is in accordance with this rule.

iii. The MCOP shall submit information regarding appeal and grievance activity, including the Monthly Aggregate State Hearing Report for Managed Care Plans (ODM 10248), as specified by ODM.

59. **Ventilator Program.** The MCOP shall comply with requirements outlined in OAC rule 5160-3-18 with regard to the alternative purchasing model for the provision of nursing facility services to ventilator dependent individuals.

60. **Utilization Management Programs.** In accordance with Sections 2.4 and 2.8 of the Three-Way, and OAC rules 5160-58-01.1 and 5160-26-03.1, the MCOP shall implement utilization management programs with clearly defined structures and processes to maximize the effectiveness of the care provided to dual benefits and Medicaid only members. Pursuant to the criteria in ORC Section 5160.34, the MCOP is prohibited from retroactively denying a prior authorization (PA) request as a utilization management strategy. In addition, the MCOP shall permit the retrospective review of a claim submitted for a service where PA was required, but not obtained, pursuant to the criteria in ORC Section 5160.34. In accordance with ORC Section 5160.34, the MCOP is required to establish a streamlined provider appeal process relating to adverse PA determinations.

    a. **Drug Utilization Management Programs.** The MCOP may, pursuant to ORC Section 5167.12, implement strategies for the management of drug utilization for Medicaid covered drugs not covered by Medicare Part D. The MCOP may, subject to ODM prior approval, require prior authorization of certain drug classes, and place limitations on the type of provider and locations where certain drugs may be administered. Concurrently, the MCOP cannot require PA for drugs used to prevent preterm birth nor can they require PA for the location of administration.

    b. **ODM Review and Approval.** The MCOP shall establish its PA system so it does not impede member access to medically-necessary Medicaid covered services. The MCOP shall comply with the provisions of OAC 5160-58-01.1 regarding the timeframes for PA of covered outpatient drugs. All proposed pharmacy programs and drug utilization management programs, such as PA, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. are subject to ODM review and approval.

c. **Behavioral Health Expedited Prior Authorization.** Assertive community treatment (ACT), intensive home-based treatment (IHBT) and substance use disorder (SUD) residential treatment (beginning with the third stay in a calendar year), shall be prior authorized as expeditiously as the member's health condition requires but no later than 48 hours after receipt of the request in accordance with OAC rules 5160-26-03.1 and 5160-58-01.1.

d. **Medicaid Covered Nursing Facility Stays.** The MCOP shall evaluate the member's need for the level of services provided by a nursing facility. To make this decision, the MCOP shall use the criteria for nursing facility-based level of care pursuant to OAC rules 5160-3-08, 5160-3-09 and 5160-1-01. The MCOP shall provide documentation of the member's level of care determination to the nursing facility. The MCOP shall maintain a written record that the criteria were met, or if not met, the MCOP shall maintain documentation that a Notice of Action was issued in accordance with OAC 5160-58-08.4. In accordance with OAC rule 5160-3-14, the preadmission screening and resident review (PASRR) process must be completed before a level of care determination can be issued. The MCOP shall have processes in place to ensure that PASRR requirements are met in accordance with OAC chapter 5160-3 prior to issuing a level of care determination.

61. The MCOP shall utilize ongoing medication reconciliation, employment of advanced practice pharmacy management programs, including medication therapy management, and in-person pharmacy consultation to increase adherence to medication regimens and eliminate contra-indicated drugs.

62. **Notification of Plan Specific Policy Changes.** In instances when the MCOP is required to provide notice to a provider regarding a change in policy as specified in this Agreement, the MCOP shall provide direct communication (e.g. email, letter, in-person meeting, etc.) to any applicable provider association(s) at least 30 calendar days prior to implementation.

The sanctions for non-compliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX D

ODM RESPONSIBILITIES

The following are the Ohio Department of Medicaid (ODM) responsibilities not otherwise stated in Ohio Administrative Code (OAC) Chapters 5160-26, 5160-58 or elsewhere in the Agreement.

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

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

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

4. ODM will provide technical assistance sessions where MCOP attendance and participation is required. ODM will also provide optional technical assistance sessions to the MCOP.

5. ODM will provide the MCOP with linkages to organizations that can provide guidance on the development of effective strategies to eliminate health disparities.

6. ODM will conduct an annual analysis of Medicaid eligible individuals to identify whether there are prevalent common primary languages other than English in the MCOP's service area. ODM will notify the MCOP of any languages identified as prevalent for the purpose of translating marketing and member materials outlined in Appendix F.

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

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

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

10. **Member Information.**

    a. ODM, or its designee, will provide membership notices, informational materials, and instructional materials to members and eligible individuals in a manner and format that may be easily understood. At least annually, ODM or its designee will provide current MCOP members with an open enrollment notice which describes the MyCare Ohio program and includes information on the MCOP options in the service area and other information regarding the MyCare Ohio program.

b. ODM will notify members or ask the MCOP to notify members about significant changes affecting contractual requirements, member services or access to providers.

c. If the MCOP 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 MCOP's members.

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

11. **Membership Selection.**

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

    b. Eligible individuals who fail to select a plan will be auto-assigned to an MCOP at the discretion of ODM in accordance with CFR 438.54.

    c. ODM or its designated entity shall provide Consumer Contact Record (CCR) to the MCOP on no less than a weekly basis. A CCR is a record of each consumer-initiated MCOP enrollment, change, or termination, and each Hotline-initiated MCOP assignment processed through the Hotline.

    d. ODM verifies MCOP enrollment via a membership roster. ODM or its designated entity provides HIPAA compliant 834 compliant daily and monthly transactions.

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

    a. ODM will confirm all premium payments paid to the MCOP during the month via a monthly remittance advice (RA).

    b. ODM or its designated entity will provide a record of each recipient detail level payment via HIPAA compliant 820 transactions. ODM or its designee will keep a record of the MCOP's Accounts Payable (e.g. Pay 4 Performance, and Health Insurance Provider Fee) and Accounts Receivable (e.g. 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 the MCOP regarding different aspects of MCOP performance including, but not limited to, information on MCOP-specific and statewide external quality review organization surveys, focused clinical quality of care studies, consumer satisfaction surveys, and provider profiles.

15. The Office of Managed Care (OMC) is responsible for the oversight of the MCOP's provider agreement with ODM. Within the OMC, a specific Contract Administrator (CA) has been assigned to each MCOP. Unless expressly directed otherwise, the MCOP shall first contact its designated CA for questions/assistance related to Medicaid and/or the MCOP's program requirements /responsibilities. If its CA is not available and the MCOP needs immediate assistance, MCOP staff should request to speak to a supervisor within the Bureau of Managed Care Compliance and Oversight.

APPENDIX E

RATE METHODOLOGY

MILLIMAN CLIENT REPORT

Calendar Year 2020 MyCare Ohio Provider Agreement Rate Certification Summary

Opt-In Capitation Rates

January 1, 2020 through December 31, 2020

Ohio Department of Medicaid

December 11, 2019

Jeremy D. Palmer, FSA, MAAA
Principal and Consulting Actuary

Marlene T. Howard, FSA, MAAA
Principal and Consulting Actuary

Jason P. Melek, FSA, MAAA
Consulting Actuary

Milliman

Table of Contents

INTRODUCTION & EXECUTIVE SUMMARY **1**

BACKGROUND 1

SECTION I. MEDICAID MANAGED CARE RATES **2**

1. GENERAL INFORMATION 2
2. DATA 4
3. PROJECTED BENEFIT COST AND TRENDS 13
4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT 18
5. PROJECTED NON-BENEFIT COSTS 20
6. RISK ADJUSTMENT AND ACUITY ADJUSTMENTS 23

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS **24**

1. MANAGED LONG-TERM SERVICES AND SUPPORTS 24

LIMITATIONS **27**

APPENDIX 1: 2020 RATE CHANGE SUMMARIES **28**

Introduction & Executive Summary

This document is an abridged version of the file titled "Calendar Year 2020 MyCare Ohio Capitation Rate Certification: Opt-In Capitation Rates" dated December 6, 2019. Please refer to the certification report for a complete version of the calendar year 2020 MyCare Opt-In capitation rate development documentation.

BACKGROUND

The Ohio Department of Medicaid (ODM), along with CMS and the MyCare Ohio plans (MCOPs), provide benefits under the MyCare Ohio (MyCare) program in targeted geographic areas. MyCare is Ohio's managed care program for the dual eligible (Medicare-Medicaid) population. Contracted MCOPs are required to provide covered services to eligible individuals through either the joint Medicare-Medicaid financial alignment initiative (Opt-In) or the Medicaid managed care program for dual eligible individuals (Opt-Out). Enrollees who select the Opt-In program become Integrated Care Delivery System (ICDS) participants in the Dual Demonstration program.

This letter provides documentation for the development of the calendar year (CY) 2020 actuarially sound capitation rates for Opt-In individuals.

Section I. Medicaid managed care rates

1. General information

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

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

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

- Actuarial standards of practice (ASOPs) applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective as of January 1, 2020.
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.
- The three-way contract between the Centers for Medicare and Medicaid Services (CMS), the MyCare Ohio plans (MCOPs), and ODM effective July 1, 2019.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" is defined as in ASOP 49:

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

A. RATE DEVELOPMENT STANDARDS

i. Annual basis

The capitation rates are effective for the one year rate period from January 1, 2020 through December 31, 2020.

ii. Differences among capitation rates

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation associated with the covered populations.

[1] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

iii. Cross-subsidization of rate cell payment

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

iv. Minimum medical loss ratio

The capitation rates were developed such that the MCOPs are reasonably expected to achieve a medical loss ratio greater than 85 percent, which includes provisions for non-benefit costs that are appropriate and attainable. The three-way contract between CMS, ODM, and the MCOPs indicates that ODM will perform medical loss ratio (MLR) calculations for the MyCare program. ODM conducts a minimum MLR requirement of 86% for the MyCare program during demonstration year 6 (DY6). If an MCOP has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment to the MCOP, the MCOP must remit the amount by which the eighty-five percent (85%) threshold exceeds the MCOP's actual MLR multiplied by the total capitation rate revenue of the contract. In the event a MCOP reports a MLR below 86% and above 85%, the MCOP would remit 50% of the difference between its MLR and 85% multiplied by the total capitation rate revenue.

B. APPROPRIATE DOCUMENTATION

i. Documentation of required elements

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

2. Data

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

A. APPROPRIATE DOCUMENTATION

i. Requested data

As the actuary contracted by ODM to provide consulting services and associated financial analyses for many aspects of the MyCare program (and not limited to capitation rate development), Milliman intakes and summarizes eligibility and expenditure data on a monthly basis using vendor files provided by ODM. Additionally, we receive the cost report data in Microsoft Excel files that the MCOPs submit to ODM on a cumulative quarterly basis, as well as final calendar year versions at each year end that include three months of claims run-out. As such, there is no separate data request from Milliman to the state specifically related to the base data for the capitation rate development. We relied on the CY 2018 encounter data for the Opt-In program as the base data for the CY 2020 capitation rate development. The remainder of this section details the base data and validation processes utilized in the CY 2020 capitation rate development.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The CY 2018 encounter data for the Opt-In program served as the primary data source for the CY 2020 capitation rate development for the MyCare Opt-In program.

The following data sources were utilized to inform adjustments to the plan-submitted encounter data:

- Historical MyCare eligibility files provided by ODM;
- Annual MyCare cost report data submitted by the MCOPs;
- Re-priced inpatient and outpatient hospital claims experience provided by ODM;
- Fee-for-service (FFS) data for dual eligibles;
- CY 2018 Survey submissions completed by each MCOP; and,
- Statutory financial statement data.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during CY 2018. The encounter data used in our rate development process reflected encounters paid through March 31, 2019, consistent with the basis of the annual cost report data. The annual cost report data reflects claims paid through March 31, 2019.

For the purposes of trend development and analyzing emerging population enrollment patterns and claims experience, we also reviewed encounter experience from CY 2016 through the first half of CY 2019. Cost report and encounter data was provided by ODM.

For the purpose of analyzing inpatient and outpatient hospital reimbursement changes, ODM provided hospital encounter data (re-priced to ODM's fee schedule) for inpatient and outpatient hospital services incurred during CY 2018. We also summarized statutory financial statement data from CY 2017, CY 2018, and the first half of CY 2019. Financial statement data was summarized using MCOP annual cost report data and subsequently reconciled using S&P Global.

(iii) Data sources

The historical encounter data experience used for this certification is submitted by the five MCOPs on an ongoing basis. This data is stored in ODM's Medicaid Information Technology System (MITS). Medicaid enrollment and encounter data stored in MITS was provided to us for the purposes of developing the CY 2020 capitation rates.

CY 2018 annual cost report data was also provided to us. The cost report data was submitted to ODM and Milliman by each of the five MCOPs in Microsoft Excel files. MCOPs submit cost reports on a cumulative quarterly basis, as well as final calendar year versions at each year end that include three months of claims run-out.

(iv) Sub-capitation

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

Encounter Data: MCOPs 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. The MCOPs provided additional information related to sub-capitated services through their CY 2018 MCOP Survey submissions. These submissions provide insight into areas where a sub-capitated arrangement is present yet the claims are not "shadow priced" in the submitted encounter data. We relied on this information for the purposes of properly identifying sub-capitated MCOP encounter data.

Cost Report: We relied on the separate reporting of non-sub-capitated and sub-capitated experience by the MCOPs in the medical cube worksheets of the CY 2018 cost reports. In the MCOP cost reports, sub-capitated expenditures represent the amounts paid by MCOPs for sub-capitated services, rather than "shadow priced" claims as illustrated in the CY 2018 encounter data.

(b) Availability and quality of the data

(i) Steps taken to validate the data

The base experience used in the capitation rates relies on cost report and encounter data submitted to ODM by participating MCOPs. Managed care eligibility is maintained in MITS by ODM. The actuary, the MCOPs, 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 MCOPs 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 MCOP performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. ODM's contract with the MCOPs stipulates encounter data specific submission and quality standards. Additionally, we perform independent analysis of encounter data and cost report data to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by either us or ODM.

Completeness

MyCare Encounter and Eligibility Data

ODM applies several measures to the MCOP-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 MCOP's fully adjudicated claims file not present in the ODM encounter data files; and,
- Percentage of encounters in the ODM encounter data files not present in the MCP's fully adjudicated claims file.

We also summarize the encounter data to assess month to month completeness of the encounter data. These measures include:

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

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

The CY 2018 MyCare Opt-In encounter data used in the development of the rates was paid through March 31, 2019. As noted in this report, claims completion is applied to the encounter data for estimated CY 2018 claims paid after March 31, 2019.

Cost Report Data

MCOPs submit quarterly and year-end annual cost report data to ODM. We review each MCOP's quarterly and annual cost reports to identify large data variances, incomplete data, and other reporting issues. These issues are provided to each MCOP 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 MCOP and reconciled to the MCOP's audited NAIC financial statement information. The year-end annual cost report is completed by the MCOPs using claims incurred in the CY 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

We reviewed the accuracy of the encounter data by comparing expenditures to outside data sources including MCOP cost report submissions along with NAIC financial statement information. We also reviewed the encounter data to ensure each claim is related to a covered individual and a covered service. 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 MCOP and service category combinations that may have unreasonable reported data.

Cost Report Data

As stated in the Completeness section, MCOPs submit quarterly and annual cost-report data to ODM. In terms of accuracy measures, the process of submitting both quarterly and annual reports identifies unreasonable or inconsistent values in the data among cost report submissions. In addition to utilization and cost metrics, financial measures such as medical loss ratio, underwriting margin, and administrative loss ratio are tracked across plans and populations. These metrics enable efficient identification of potential cost allocation issues. We also evaluated the cost report expenditures in relation to statutory financial statements for each MCOP to ensure expenditure differences were reasonable.

Consistency of data across data sources

We performed a detailed review of the encounter data used in the development of capitation rates effective January 1, 2020. Assessing the encounter data for consistency with the MCOP cost reports was a vital part of the rate development process. We reviewed PMPM values by rate cell and region for CY 2018 encounter data and CY 2018 cost reports. Experience was reviewed for non-sub-capitated services, sub-capitated services, and in aggregate. Aggregate expenditures in the encounter data were approximately 23% less than aggregate expenditures in the cost report data (prior to any data quality adjustment). The main difference between the encounter data and cost report expenditures are attributable towards one of the five MCOPs having an encounter data reporting process, approved by CMS, that is different than the remaining four MCOPs. This reporting process results in a significant shortage in claim payments contained in the Opt-In encounter data compared to the cost reports for the one MCOP. Other differences between the encounter data and cost report expenditures were generally attributable to service categories where a large portion of the expenditures were sub-capitated, due to differences in the reporting of sub-capitated expenditures between the two data sources (shadow-priced versus ceded premium). As described in section II item B.3 of this report, we went through an interactive process in conjunction with ODM and the MCOPs to adjust the CY 2018 Opt-In encounter data such that it could be relied upon as the base data for the CY 2020 Opt-In capitation rates.

(ii) Actuary's assessment

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

We find the encounter data used as the base data source for the development of the 2020 capitation rates to be of appropriate quality and suitable for the purpose of developing actuarially sound rates (subject to the data concerns and resolutions indicated in the Data concerns section below). The resulting base data PMPM expenditures for CY 2018, after the application of the adjustments, is within approximately 1.2% of the CY 2018 cost report PMPM expenditures. The encounter data additionally appears reasonable in relation to Medicaid dual eligible managed care industry experience.

(iii) Data concerns

Through discussions with ODM and various data analyses, we were made aware of and confirmed adjustments which were necessary to apply to the CY 2018 encounter data as follows:

- Apply missing encounter data adjustments as provided by the MCOPs in the 2018 MCOP Survey. Remove non-state plan services from cost report and encounter expenditures.
- Remove delegated admin from cost report sub-capitated expenditures, apply data quality adjustment to encounter data as warranted. State both cost report and encounter expenditures on a net basis for TPL and F&A.
- Remove enrollment counts and claims for members with IMD stays greater than 15 days in a calendar month.

We have not identified any material concerns with the quality or availability of the encounter data, other than those listed above.

(c) Appropriate data

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

FFS claims and enrollment were not used as the primary data source for this certification. Rather, the FFS data was used to assist with the development and verification of program and pricing adjustments and other modeling assumptions. The FFS data used to supplement the CY 2020 rate development reflects historical experience and covered services closely aligned with the MyCare program.

(ii) Use of managed care encounter data

The CY 2018 Opt-In encounter data is the primary data source used in the development of the capitation rates.

(d) Reliance on a data book

Development of the capitation rates did not rely on a data book or other summarized data source. We were provided with detailed claims data for all covered services and populations. We created data books summarizing CY 2018 encounter data, which were shared with ODM and participating MCOPs.

iii. Data adjustments

Capitation rates were developed primarily from CY 2018 encounter data. Adjustments were made to the base experience for data quality, completion, reimbursement changes, regional stratification, and other program adjustments.

(a) Credibility adjustment

In total, the statewide MyCare Opt-In program experience was fully credible. While we did not apply an explicit credibility adjustment to the data, we did develop the Opt-In capitation rates at the region and rate cell level. To mitigate any credibility concerns at the regional level and to preserve potentially proprietary MCOP information in regions where only two MCOPs are present, we developed factors to stratify the statewide Opt-In experience into

regional summaries. These factors were primarily informed by the combined CY 2018 Opt-Out and Opt-In encounter data.

(b) Completion adjustment

The capitation rates are based on CY 2018 Opt-In program experience. Encounter data is paid through March 31, 2019. Completion factors were developed by summarizing encounter data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability, using Milliman's Robust Time-Series Analysis System (RTS)[2].

First, we stratified the data by category of service. Claims for each of these population-service category stratifications were analyzed and formed into lag triangles by paid and incurred month. Claim completion factors were developed for each month of the base experience period, based on historical completion patterns. Completion factors developed through the use of encounter data were compared to MCOP reported IBNP liability estimates in the CY 2018 MCOP Cost Reports. Although the completion adjustments were similar, we elected to apply completion adjustments based on our calculated IBNP liabilities rather than the IBNP liabilities reported by the MCOPs.

The monthly completion factors were applied to CY 2018 experience to estimate the remaining claims liability for the calendar year.

(c) Errors found in the data

Through discussions with ODM and our independent review of the data, we applied adjustments to the CY 2018 encounter data to create the base data for the capitation rate development.

(d) Program change adjustments

The subsectiions below include details related to the program and reimbursement changes that have occurred in the MyCare program since January 1, 2018, the beginning of the base experience period used in the capitation rate development.

Calendar Year 2017

IMD as an "In Lieu of" Service. Effective July 1, 2017, ODM began permitting the use of IMDs as an "in lieu of" service for the 21 to 64-year-old population for up to 15 days per month. This program change was implemented in compliance with the conditions outlined in the final Medicaid managed care regulations. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD. The unit cost for IMD services was developed based on the cost per admit of Inpatient Psychiatric/SA services for non-teaching hospitals for the Medicaid Managed Care (MMC) aged, blind, and disabled (ABD) adult population.

Calendar Year 2018

Serious Mental Illness (SMI) Health Home.

Effective July 1, 2018, ODM discontinued its SMI Health Home program. These services, which were previously billed under HCPCS S0281, were primarily utilized by members residing the Northwest and Southwest regions. We reviewed first-half (1H) and second-half (2H) 2018 utilization for the providers who previously rendered S0281, and observed material increases in utilization for services other than S0281 following the sunset of the SMI Health Home. For these codes, we calculated the impact of 1H 2018 utilization increasing to levels consistent with 2H 2018.

[2] The Robust Time Series Reserve Analysis System (RTS) is a model designed to assist an actuary in performing an Incurred But Not Paid (IBNP) reserving analysis. The RTS is unique because it contains functionality that: provides reasonable best estimates in spite of contaminated data, provides reasonable margins for the total reserve, independently models shock claims, and provides forecasts of future cash flows. This methodology forecasts future claim runout using time series forecasting which employs the interrelationship between claim payments during the first three months of claim payments for each incurred month.

Nursing Facility Per Diem Updates.

In the MyCare program, the plans are required to pay the NFs at the same rates used by ODM for FFS claims. ODM currently updates the NF payment rates and acuity scores on a semi-annual basis. An adjustment was applied to reflect the regional impact of the semi-annual NF per diem update, effective July 1, 2018. We estimated the impact of the semi-annual per diem update at the population group and region level based on NF per diem updates by provider.

Ventilator-Dependent Nursing Facility Rate Change.

Effective July 1, 2018, ODM began reimbursing nursing facilities for the higher costs associated with caring for individuals who are ventilator-dependent at an elevated per diem rate equal to $645.00. We estimated the impact of the NF per diem update at the population group level based on repricing the average NF per diem to the higher ventilator-dependent per diem for individuals identified as ventilator-dependent.

Calendar Year 2019

Ventilator-Dependent Nursing Facility Rate Change.

Effective January 1, 2019 ODM updated the nursing facility per diem rates to $754.22 for individuals who are ventilator-dependent and to $905.06 for individuals who are weaning off ventilator dependence. Effective July 1, 2019, ODM increased the nursing facility per diem rates to $819.49 for individuals who are ventilator-dependent and to $983.39 for individuals who are weaning off ventilator dependence. We relied on information from ODM related to the assumption that approximately 29% of individuals will have attempts to wean of ventilator dependence, and approximately 23% of those attempts are estimated to be successful. Based on this information, we estimated the impact of the NF per diem update at the population group level based on repricing the average CY 2019 projected NF per diem to the ventilator-dependent per diem for individuals identified as ventilator-dependent.

Home Delivered Meals Fee Change

Effective January 1, 2019, ODM implemented a reimbursement change for home delivered meals which aligns the rates for all eligibility groups in managed care and FFS. The reimbursement change included separate rates for standard meals at $6.50, and alternate meals for specific dietary needs at $8.68. We estimated the impact to waiver service expenditures associated with the home delivered meals fee changes.

Emergency Response Systems Fee Change

Effective January 1, 2019, ODM implemented a reimbursement change for emergency response systems which aligns the rates for all eligibility groups in managed care and FFS. The revised reimbursement rate for emergency response systems installation and monthly rental increased to $32.95. We estimated impact to waiver service expenditures at the population group level associated with the emergency response systems fee change.

Behavioral Health Fee Schedule Changes.

Effective August 1, 2019, ODM implemented policy and payment rate changes for the following behavioral health (BH) services, reflected in Ohio Administrative Code (OAC) rule 5160-27-03, which will result in an increase to projected provider reimbursement:

- Crisis Services: Crisis services for both Mental Health (MH) and Substance Use Disorder (SUD) treatment received a 30% fee increase for certain impacted billing codes.
- Group Therapy: Group Psychotherapy, MH Therapeutic Behavioral Services (TBS), and SUD Counseling services received a 30% fee increase for certain impacted billing codes.
- Evaluation and Management (E&M) Services: E&M services and diagnostic psychiatric evaluations provided by Certified Nurse Practitioners, Clinical Nursing Specialists, and Physician Assistants at BH providers are subject to reimbursement at 100% of the Medicaid maximum rate, which is an increase from the previous policy of 85%.

- Individual TBS: Licensed clinicians employed by BH agencies are allowed to render TBS in an individual setting. We anticipate providers who were previously rendering Community Psychiatric Supportive Treatment (CPST) will now provide TBS at a higher reimbursement rate.

To estimate the impact of the above items, we used CY 2018 BH encounters and FFS claims along with CPT and HCPCS-level rate increase assumptions provided by ODM.

Calendar Year 2020

Inpatient Reimbursement Changes.

Effective January 1, 2020, ODM will rebase its inpatient hospital base rates through the continued use of All Patients Refined Diagnosis Related Groups (APR DRG). This includes revised APR DRG relative weights along with updated hospital base rates.

Outpatient Reimbursement Changes.

Effective January 1, 2020, ODM will rebase its outpatient hospital payments through the continued use of the Enhanced Ambulatory Patient Grouping System (EAPG). This includes accommodation of the latest EAPG grouper version, updated EAPG relative weights, and updated base rates by hospital.

Nursing Facility Reimbursement Changes.

In the MyCare program, the plans pay the NFs at the same rate used by ODM for FFS claims. ODM updates nursing facility payment rates and acuity scores on a semi-annual basis. We applied adjustments to reflect the impact of the semi-annual per diem updates which were effective January 1, 2019, July 1, 2019, and anticipated for January 1, 2020. Adjustments were applied to the nursing facility and hospice room and board categories of service, and vary based on differences in base nursing facility experience by population group and region.

Waiver Rate Increase.

ODM anticipates increasing the reimbursement for certain waiver nursing and personal care services. Using CY 2018 encounter data, we evaluated the impact of this program adjustment by estimating paid claim amounts under 2018 ODM reimbursement and 2020 ODM reimbursement levels to determine the percentage impact to waiver services.

Other Fee Schedule Changes.

We reviewed other known fee schedule changes for changes effective between the start of CY 2018 and CY 2020.Through the use of fee schedules provided by ODM, as well as 5160-1-60 Appendix DD, we estimated the impact of these fee schedule changes and applied rating adjustments to impacted categories of service. Using CY 2018 encounter data, we evaluated the impact of this program adjustment by estimating paid claim amounts under 2018 ODM reimbursement and 2020 ODM reimbursement levels to determine the percentage impact to applicable services. The impact of these reimbursement changes was calculated net of the impact of the change to the Medicaid maximum payment methodology.

Population Morbidity Changes.

We applied adjustments to account for estimated population morbidity differences between calendar year 2018 and calendar year 2020. Adjustments were applied to account for known population changes based on data provided by ODM. Items considered when developing these adjustments are outlined below.

- **Duplicate Member IDs**. We were informed of the potential for duplicate member IDs in the vendor file eligibility information we received. We removed member months associated with duplicate member IDs to the extent these members remained in CY 2018.
- **Deceased Members**. ODM provided member identification information for individuals who have been identified as deceased, but were not reported as deceased in the encounter data. We reduced the member months from the eligibility underlying the encounter data for enrollment reported after the date of death of a member.

- **Spenddown Population**. Between July and October 2018, the former spenddown population began enrolling in the MyCare program. We received a listing of former Spenddown recipient IDs from ODM, and utilized this information to develop enrollment and morbidity impacts associated with the introduction of this population.
- **Specialized Recovery Services (SRS) Population**. Beginning October 2018, members eligible for Medicaid under the 1915(i) waiver were enrolled in mandatory managed care. We received a listing of SRS recipient IDs from ODM, and utilized this information to develop enrollment and morbidity impacts associated with the introduction of this population.
- **Enrollment Backlog**. ODM identified a backlog of individuals eligible for the MyCare program that were enrolled in the fee-for-service Medicaid program. We received a listing of the enrollment backlog recipient IDs from ODM, and utilized this information to develop the estimated impact associated with the introduction of this population. We anticipate that the morbidity of this population will be consistent with the morbidity of the existing MyCare program, and will continue to monitor this population as emerging experience becomes available.

We estimated the morbidity impact at the regional level for the anticipated new populations as follows:

- On a statewide basis, we summarized CY 2018 FFS claims experience for the new populations using member IDs provided by ODM, and compared their costs to the CY 2018 base data PMPM for the base population, to develop a cost relativity. We estimated the cost relativities for the following service groupings:
    - Non-behavioral health acute care services
    - Behavioral health services
    - Long-term care services

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 MyCare program during CY 2020 that are not fully reflected in the CY 2018 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 MCOPs. *We defined a program adjustment to be 'material' if the total benefit expense for any individual rate cell is impacted by more than 0.1%.* In addition, program adjustments that were determined to be material in prior rate setting activities, but that may have an immaterial impact in the 2020 MyCare capitation rate development, are outlined in the program adjustment sections above. The following is a list of program adjustments deemed immaterial based on our review of the experience data and policy change.

- **APRN Prescribing.** There was a provision in MCDCD49 allowing an Advanced Practice Registered Nurse (APRN) who is certified in psychiatric mental health by a national certifying organization to prescribe atypical antipsychotics and antidepressant drugs without going through prior authorization. This provision already exists for psychiatrists. Given the existing high rate of prescribing for "preferred" agents, we do not anticipate a material shift in volume to more expensive agents.
- **Laboratory Contract and Community SUD Treatment Providers.** Effective January 1, 2019, substance use disorder (SUD) providers (provider type 95) with appropriate CLIA certifications will be able to perform on-site laboratory services. Based on information provided by ODM, we do not anticipate that this program adjustment will result in a material increase in laboratory service expenditures.
- **Pharmacist Administered Injectables.** Effective January 1, 2019, pharmacists administering injection drugs shall be provided an administration fee at the point-of-sale from the MCOPs (as allowed under Ohio Administrative Code (OAC) rule 4729-5-40). Based on information provided by ODM, we do not anticipate incremental costs associated with this program change.

Each of the program adjustments listed above were determined to be immaterial on a stand-alone basis (i.e., impacted the rates by less than 0.1%). We evaluated the composite impact of all of the immaterial items listed above to assess whether an aggregate impact should be applied in the CY 2020 rate development process. Based on this analysis, the impact of immaterial program adjustments is immaterial on a composite basis (i.e., impacted the rates by less than 0.1%), so no further adjustments were applied.

(e) Exclusion of payments or services from the data

The following adjustments were made to the base experience data to reflect pharmacy rebates, third party liability recoveries, and non-encounter claims payments.

Services excluded from initial base data summaries

Non-State Plan Services

We excluded all services included in the encounter data that do not reflect approved state plan services (nor are an approved in-lieu-of service).

Institution for Mental Disease (IMD) Stays Greater than 15 Days

We excluded all costs for enrollees aged 21 to 64 associated with an IMD stay of more than 15 days in a calendar month. This exclusion included any other costs outside of the IMD for any services delivered during the time an enrollee was in the IMD for more than 15 days.

Third Party Liability/Fraud and Abuse

In addition to actual cost avoidance reflected in the encounter data, we estimated additional third party liability (TPL) and fraud recoveries based on data available in CY 2018 cost reports and MCOP surveys.

Adjustments made to base data

Upon review of 2018 cost reports and MCOP surveys, we adjusted the base data for the following items:

- Pharmacy Rebates
- Net Reinsurance

3. Projected benefit cost and trends

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

A. RATE DEVELOPMENT STANDARDS

i. Final Capitation Rate Compliance

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). Non-state plan services provided by the MCOPs have been excluded from the capitation rate development process. Effective July 1, 2017, ODM began permitting the use of IMDs as an in-lieu-of service for the 21 to 64-year-old population for up to 15 days per month.

ii. Basis for Variation in Assumptions

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

iii. Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the Opt-Out MyCare program. The Opt-In data was not used for trend development as this data was not historically used to set the Opt-In capitation rates, and has not gone through the data validation process for years prior to 2018.

iv. In Lieu Of Services

As noted earlier, ODM began permitting the use of IMDs as an in-lieu-of service effective July 1, 2017. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

v. Benefit expenses associated with members residing in an IMD

We reviewed benefit costs for enrollees aged 21 to 64 during the base experience period to identify costs associated with an Institution for Mental Diseases (IMD) stay of more than 15 days in a month and any other MCOP costs for services delivered in a month when an enrollee had an IMD stay of more than 15 days. These costs were identified and removed from the encounter data. In addition, as noted above we did not use the unit cost of the IMD as an in-lieu-of service, and instead utilized the unit cost for that of existing state plan providers.

B. APPROPRIATE DOCUMENTATION

i. Projected Benefit Costs

This section provides the documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

ii. Development of Projected Benefit Costs

(a) Description of the data, assumptions, and methodologies

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

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

The capitation rates were primarily developed from historical expenditure and enrollment data experience in CY 2018. This data consists primarily of CY 2018 incurred encounter data that has been submitted by the MCOPs adjusted for known missing claims reported in the CY 2018 MCOP Survey submissions. Additionally, CY 2018 MCOP cost report data has been utilized to supplement cost information for certain service categories where the encounter data PMPMs did not appear to be reasonable.

Step 2: Apply base data adjustments to cost summaries

The base experience period was adjusted for the items previously outlined. The development of the regional stratification factors applied to the statewide Opt-In base data encompassed data smoothing techniques for low credibility populations and to preserve potentially proprietary MCOP information at the regional level. For example, we evaluated the grouping of nursing facility level of care (NFLOC) populations, Community Waiver populations, and/or Community Well populations as appropriate to develop the regional stratification factors applied to each population. We utilized relativities observed in the CY 2018 encounter data and the CY 2018 cost reports in composite for the MyCare Opt-In and Opt-Out programs to develop the regional stratification factors. The factors were developed to maintain budget neutrality across the base data experience.

We developed region factors by major service category at the rate cell level. For retrospective program adjustment factors, the adjustments were developed at either the statewide total level, or at the population and/or regional level as appropriate.

Step 3: Adjust for prospective program and policy changes and trend to calendar year 2020

Adjustment factors were developed and applied to the CY 2018 base experience to reflect known policy and program changes that have occurred or are expected to be implemented in calendar years 2018 through 2020. Full documentation of currently known items that were considered in the rate development is provided in this report. The adjusted PMPM values from the base experience period were trended forward to the midpoint of the contract period (July 1, 2020). Adjustments were applied to the PMPM values to reflect program changes between the base period and effective rate period. The resulting PMPMs establish the adjusted claim cost by population for the contract period. Consistent with step 2, program adjustment and trend factors were developed at either the statewide total level, or at the population and/or regional level, as appropriate.

Step 4: Incorporate non-benefit items and adjustments

The CY 2020 capitation rates include an allowance for non-benefit cost items. This includes care management costs, administrative allowance, Health Insuring Corporation (HIC) tax, HIC Franchise Fee, and provision for margin. The provision for margin includes items such as cost of capital, risk mitigation, contingency, underwriting gain, and profit.

Note that MCOPs will receive a separate payment from ODM for the Health Insurer Fee (HIF) as appropriate.

Step 5: Composite nursing facility level of care (NFLOC) rating cell

The Institutional and Community Waiver populations were combined to create the NFLOC rates by region. We applied a 0.5% rebalancing shift between NFLOC beneficiaries residing in NFs and a community setting to the current composite enrollment in MyCare to develop the projected enrollment distribution for 2020.

This step does not apply to the Community Well capitation rate cells.

Other material adjustments - managed care efficiency

The base data represents the MyCare managed care population in CY 2018, and the projected CY 2020 enrollment represents Opt-In enrollment as of July 2019, with assumptions for SRS recipients and former spenddown members who enrolled in the Opt-In program during CY 2019. We expect continued improvement in managed care for the NFLOC population, and therefore applied a 0.5% rebalancing shift between NFLOC beneficiaries residing in NFs and a community setting. We did not apply any further managed care adjustments.

(b) Material changes to the data, assumptions, and methodologies

In our development of the capitation rates for the Opt-In program in CY 2019, we relied on regulatory guidance related to the capitation rate setting methodology and the mandatory joint savings percentage required by the three-way contract. The CY 2019 Opt-In capitation rates were developed from the projected benefit expenses underlying the Opt-Out capitation rates (baseline Medicaid data).

The baseline Medicaid data was adjusted for the following factors:

- Selection adjustments
- Application of non-benefit expenses
- Application of 4% joint savings as required under demonstration year 5

Material changes to the rate development methodology described above include:

- The CY 2020 MyCare Opt-In capitation rates were developed using Opt-In encounter data with adjustments consistent with the rate development standards outlined in 42 CFR 438.5.
- The primary base data source has changed from the projected benefit expenses underlying the Opt-Out capitation rates to the CY 2018 Opt-In MyCare encounter data.
- The 4% joint savings is no longer applied to the Medicaid component of the MyCare Opt-In capitation rates.

All material assumptions and the overall methodology utilized to develop the capitation rates are documented in this rate certification report.

(c) Provider Overpayments

To the best of our knowledge, all information related to any payment recoveries not reflected in the base period encounter data was provided to us by the MCOPs in their survey responses, and the CY 2018 base data was adjusted to reflect any such recoveries.

iii. Projected Benefit Cost Trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (CY 2018) to the CY 2020 rating period of this certification. We evaluated prospective trend rates using ODM data, as well as external data sources.

The trends are illustrated on a PMPM basis and primarily reflect utilization and mix/intensity of services. ODM-specific policy changes that impact CY 2020 provider reimbursement are handled through the program adjustments previously outlined.

(a) Required elements

(i) Data

The CY 2016 through 2018 MCOP Opt-Out encounter data was the primary source for the development of estimated prospective trend rates. As previously discussed, Opt-In data was not used for trend development as this data was not historically used to set the Opt-In capitation rates, and has not gone through a detailed review process to determine its reliability prior to CY 2018.

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. 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.

(ii) Methodology

For internal ODM data, historical per member per month cost data was stratified by month, population, and category of service. The data was normalized for material program adjustments to reflect a consistent reimbursement and covered benefit structure across the historical data period. We used linear and time series regression analyses to project experience during the contract period. Contract period projections were compared to base period experience to determine an appropriate annualized trend. The data was adjusted for completion and the resulting historical trends were summarized as a data point in our process.

(iii) Comparisons

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

We referred to the sources listed in the prior section as well as considered changing practice patterns, the impact of reimbursement changes on utilization in the MyCare population, and the shifting population mix.

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

(iv) Documentation

As discussed previously, 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 MCOP encounter data trend experience due to anomalies observed in the historical trend data. We referred to the sources listed in the prior section as well as considered changing practice patterns, the impact of reimbursement changes on utilization in the MyCare population, and the shifting population mix.

We have not included any outlier or negative trends for the development of the CY 2020 capitation rates.

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

We have reviewed ODM's final report regarding compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as required by 42 CFR 438.3(c)(1)(ii). Results of the analysis indicate full compliance with MHPAEA for both quantitative and non-quantitative treatment limits with no remediation needed that would constitute a program adjustment. Based on the final results, we have not made any rating adjustments to accommodate parity compliance.

v. In Lieu of Services

Effective July 1, 2017, ODM began permitting the use of IMDs as an in-lieu-of service for the 21 to 64-year-old population for up to 15 days per month. This program change was implemented in compliance with the conditions outlined in the final Medicaid managed care regulations. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers. IMD as an in-lieu-of service is contained within the "Inpatient Hospital" service category, and is not included in any other service categories.

vi. Retrospective Eligibility Periods

(a) MCOP responsibility

The MCOPs are responsible for retrospective eligibility periods when the beneficiary was previously enrolled with an MCOP in the MyCare program less than 90 days prior to re-enrolling with an MCOP. ODM provides capitation payments to the MCOPs for beneficiaries meeting this criteria.

(b) Claims treatment

No base data adjustment was required for retroactive eligibility.

(c) Enrollment treatment

Enrollment is treated consistently with claims. We have not adjusted for retrospective eligibility.

(d) Adjustments

As previously mentioned, no explicit adjustment was applied for the CY 2020 rate setting.

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the July through December 2019 rating period. This certification applies to the CY 2020 effective period.

(a) Change to covered benefits

Material changes to covered benefits have been described in a previous section.

(b) Recoveries of overpayments

To the best of our knowledge, all information related to any payment recoveries not reflected in the base period encounter data was provided to us by the MCOPs in their survey responses and the CY 2018 base data was adjusted to reflect any such recoveries.

(c) Change to payment requirements

Material changes to required provider payments have been described in a previous section.

(d) Change to waiver requirements

There were no material changes related to waiver requirements or conditions.

(e) Change due to litigation

There were no material changes due to litigation.

viii. Documentation of Material Changes

The estimated impact of material changes to covered benefits and provider payments have been quantified in program adjustments described in a previous section. This information includes the data, assumptions, and methodology used in developing the adjustment, estimated impact by population, and aggregate impact on the managed care program's benefit expense. Non-material changes to covered benefits or provider payments have also been described in this section of the report.

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate Development Standards

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

ii. Appropriate Documentation

There are no bonuses or incentives offered in the MyCare Opt-In program.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the withhold arrangement in the MyCare program.

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period and purpose

The withhold arrangement is measured on a calendar year basis. For CY 2020, the percent of withhold amounts repaid to each MCOP for the Opt-In program will be determined in accordance with the 'CMS Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes'. This document also outlines the CMS core measures evaluated in the withhold analysis performed by CMS.

(ii) Description of total percentage withheld

Withholds constitute 3% of the certified rates for CY 2020. The capitation rates shown in this letter are illustrated before offset for the withhold amount; however, the CY 2020 capitation rates documented in this report are actuarially sound while considering the amount of the withhold not expected to be earned.

(iii) Estimate of percent to be returned

Based on our review of information provided by ODM, as well as the "Ohio Medicare-Medicaid Plan Quality Withhold Analysis Results for Demonstration Year 3" applicable to CY 2017, we believe that a full withhold return is attainable by the MCOPs[3].

(iv) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 3% of capitation revenue indicates that it is reasonable within the context of the capitation rate development and the magnitude of the withhold does not have a detrimental impact on the MCOP's financial operating needs and capital reserves. Our interpretation of financial operating needs relates to cash flow needs for the MCOP to pay claims and administer benefits for its covered population. We evaluated the reasonableness of the withhold within this context by reviewing the MCOP's cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by ODM.

(v) Effect on the capitation rates

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

(b) Certification of Withhold Arrangement

As previously stated in this report, we believe that a full withhold return is attainable by the MCOPs. Therefore, the rate is certified as actuarially sound without removal of any portion of the withhold.

[3] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReportOHDY3.pdf. Accessed 10/16/2019

C. RISK SHARING MECHANISMS

i. Rate Development Standards

This section provides documentation of the risk-sharing mechanisms in the MyCare program.

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

There are no risk-sharing mechanisms in the MyCare Opt-In program.

(b) Medical Loss Ratio

The three-way contract between CMS, ODM, and the MCOPs indicates that ODM will perform medical loss ratio (MLR) calculations for the MyCare program. ODM conducts a minimum MLR requirement of 86% for the MyCare program during demonstration year 6 (DY6). If an MCOP has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment to the MCOP, the MCOP must remit the amount by which the eighty-five percent (85%) threshold exceeds the MCOP's actual MLR multiplied by the total capitation rate revenue of the contract. In the event a MCOP reports a MLR below 86% and above 85%, the MCOP would remit 50% of the difference between its MLR and 85% multiplied by the total capitation rate revenue.

(c) Reinsurance Requirements and Effect on Capitation Rates

MyCare MCOPs are required to maintain minimum reinsurance protection as set out in the Ohio Administrative Code. The 3-way contract for the Opt-In program outlines specific requirements. Opt-Out requirements are consistent with the Opt-In requirements. We have adjusted expenses in the historical period by the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) as reported in the 2018 annual cost report data. Reinsurance recoveries were based on amounts reported in MCOP cost report data.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

This section is not applicable because there are no payment incentives for the MyCare program as defined by the CMS Rate Setting Guide.

E. PASS-THROUGH PAYMENTS

This section is not applicable because there are no pass-through payments for the MyCare program as defined by the CMS Rate Setting Guide.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR §438.5(e), the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to MCOP operation of the MyCare program.

The remainder of this section provides documentation of the data, assumptions and methodology that we utilized to develop the non-benefit cost component of the capitation rate.

ii. PMPM versus percentage

The non-benefit cost was developed as a percentage of the capitation rate for general administrative costs and margin, and as a PMPM for care management.

iii. Basis for variation in assumptions

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

iv. Health insurance providers fee

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

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

(a) Description of the data, assumptions, and methodologies

Data

The primary data sources used in the development of the CY 2020 non-benefit costs are listed below:

- Annual and first half 2019 cost report data submitted by the MCOPs.
- CY 2018 MCOP Survey completed by each MCOP.
- Statutory financial statement data for each of the MCOPs.

Assumptions and methodology

In developing the administrative costs, we reviewed the CY 2016, through first half 2019 cost reports and found a significant amount of variation in the reporting of administrative expenses between the five MCOPs, both in the magnitude of administrative expenses and in the rate cell allocation methodology utilized.

Cost report administrative expenses for both the Opt-Out and Opt-In MyCare programs were analyzed by MCOP for reasonableness and completeness of the data provided. For MCOPs with unreasonable administrative expense rate cell allocation, we reallocated their total administrative costs using the rate cell administrative expense distribution of the other MCOPs. This data formed the baseline for projected 2020 administrative expense amounts. Separate administrative expenses amounts were developed for each rating group.

(b) Material changes

Projected non-benefit costs for CY 2020 include a risk margin decrease from 3% in the CY 2019 capitation rates to 2% in the CY 2020 capitation rates. This decrease reflects an assumption of reduced risk related to the maturity of the program, enrollment volume, and the ability to develop capitation rates independently between Opt-In and Opt-Out for the MyCare program.

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

(c) Other material adjustments

There are no other material adjustments applicable to the non-benefit cost component of the capitation rate.

ii. Non-benefit costs, by cost category

(a) Administrative expenses

Administrative expenses have not been developed from the ground up (based on individual components). However, individual components were reviewed within MCOP 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 CY 2020 non-benefit cost allowance is determined as a percentage of the capitation rates before fees and taxes.

(b) Care coordination and care management

Care coordination and care management is calculated on a PMPM basis separately from general administrative expenses in the MyCare program.

AAA Plus Plan Management: Community Waiver Enrollees 60+

MCOPs are required to contract with Area Agencies on Aging (AAAs) to perform core waiver coordination services for members who are 60 years or older and on a 1915(c) waiver. Care management (plan management) for coordination of non-core services must be provided by the plans as well, but is not required to be provided through the AAAs.

Based on discussions with ODM, we assumed a 2.0% increase to the CY 2019 AAA Plus Plan Management PMPM costs for CY 2020.

Plan Management: Other Populations

Neither waiver coordination services nor non-waiver care management services are required to be contracted with the AAAs for the other MyCare populations. Thus, the total care management costs are additionally referenced as plan management costs. Upon review of the total care management costs from the CY 2016 through first half 2019 cost reports, we determined that the care management costs represent approximately half of total administrative expenses for all MCOPs in composite. We determined that a 50% distribution between care management expenses and other administrative expenses, after rebasing of the Community Waiver 60+ costs, would result in a reasonable composite normalized PMPM in comparison to the first half 2019 cost report data.

The care management costs for the Community Waiver 45-64 population were developed as a member weighted average of the Community Waiver 18-44 plan management PMPM and the AAA Plus Plan Management PMPM Costs.

(c) Health insuring corporation franchise fee

Fees and Taxes are loaded to the capitation rates after the application of non-benefit expenses. This includes the Health Insuring Corporation (HIC) Franchise Fee along with the HIC tax. The HIC Franchise Fee consists of a PMPM amount that varies based on an entity's Medicaid member months. The development of the actuarially sound capitation rates includes HIC Franchise Fee (collected by ODM) and HIC tax (collected by the Ohio Department of Insurance) components. HIC Franchise Fee amounts were developed by MCOP based on projected Medicaid member months for January through June 2020, and then weighted based on regional enrollment by MCOP. As the HIC Franchise Fee is assessed on a state fiscal year basis, we anticipate amending the CY 2020 capitation rates to reflect HIC Franchise Fee amounts applicable to July through December 2020. The HIC tax will remain at 1% of the total capitation rate.

iii. Health insurance providers fee

(a) Whether the fee is incorporated in the rates

As applicable, CY 2020 rates will be amended based on the calculated HIF attributable to ODM premium revenue, consistent with ODM's payment of the HIF in prior years. To the extent the actual paid HIF is less than the calculated HIF, the rates for the MCOP will be amended based on actual paid HIF.

(b) Fee year or data year

The HIF for each insurer is calculated based on the data year. Amended CY 2020 rates will be based on the 2021 HIF attributable to the 2020 data year, as applicable.

(c) Determination of fee impact to rates

As applicable, the calculation of the fee for each MCOP 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 MCOPs subject to the HIF, Form 8963 premium amounts attributable to ODM, data year HIF tax percentage, and adjustments for premium revenue based on benefits described in 26 CFR 57.2(h)(2)(ix) such as nursing home and home health care. Final fee amounts are adjusted for applicable fees and taxes that are applied to ODM capitation rate revenue (documented in the non-benefit expense section of this report).

(d) Timing of adjustment for health insurance providers fee

The 2020 capitation rates will be amended based on any applicable HIF in 2021 attributable to the 2020 data year. We anticipate amending the rates in the last quarter of CY 2021.

(e) Identification of long-term care benefits

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

(f) Application of health insurance providers fee in 2014, 2015, 2016, and 2018 capitation rates

The MCOPs were required to pay the HIF in 2014, 2015, 2016, and 2018. For each year, the initially certified capitation rates were adjusted to include the HIF and associated income tax impacts to reflect the non-tax-deductibility of the HIF.

6. Risk Adjustment and Acuity Adjustments

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

A. RATE DEVELOPMENT STANDARDS

i. Overview

The MyCare rates have been developed as full risk rates. The MCOPs assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract. The regional NFLOC rates will be prospectively adjusted by MCOP to reflect mix differences in the enrolling population between nursing facility and Community Waiver setting of care. This adjustment will be made to the rates prospectively. No additional risk adjustment is planned for this population in CY 2020.

ii. Risk adjustment model

For the prospective member mix, we will continue to employ member enrollment mix adjustment (MEMA). This methodology adjusts the NFLOC capitation rates based on a MCOP's mix of nursing facility and Community Waiver membership.

iii. Acuity adjustments

Acuity adjustments are not applicable to the CY 2020 capitation rates.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data and adjustments

- The MEMA is a budget-neutral adjustment which will be updated January and July of each year.
- October 2019 MyCare Opt-In enrollment data is anticipated to be used for the January 1, 2020 through June 30, 2020 MEMA development.
- April 2020 MyCare Opt-In enrollment data is anticipated to be used for the July 1, 2020 through December 31, 2020 MEMA development.

MEMA will account for the variation in HIC Franchise Fee payments by MCOP. MEMA will be applied to the CY 2020 capitation rates less the HIC Franchise Fee and tax amounts. We will then apply MCOP-specific HIC Franchise Fee and tax amounts to the normalized rates on a budget neutral basis. Community Well rate cells are excluded from MEMA; however, they are subject to the HIC Franchise fee. For these rate cells, we will apply adjustments to account for variation in projected HIC Franchise Fee amounts by MCOP.

(b) Risk adjustment model

For the prospective member mix, we will continue to employ MEMA. This methodology adjusts the NFLOC capitation rates based on a MCOPs mix of nursing facility and Community Waiver membership. We will provide full documentation of these results and methodology for MEMA analysis in a separate correspondence.

(c) Risk adjustment methodology

The MEMA adjustment is applied by region for the NFLOC rate cell for each MCOP. Each population group within the NFLOC rate cell is given a weight based on its relative capitation rate compared to the composite NFLOC capitation rate. Each MCOP will receive a calculated MEMA score based on their enrollment of each population group within the NFLOC rate cell. To ensure budget neutrality, the MEMA scores will be normalized to 1.000 for each region. MEMA methodology uses generally accepted actuarial principles and practices.

Section II. Medicaid Managed care rates with long-term services and supports

1. Managed Long-Term Services and Supports

A. COMPLETION OF SECTION I

MyCare is Ohio's managed care program for the dual eligible (Medicare-Medicaid) population. Contracted MCOPs are required to provide covered services to eligible individuals through either the joint Medicare-Medicaid financial alignment initiative (Opt-In) or the Medicaid managed care program for dual eligible individuals (Opt-Out). Enrollees who select the Opt-In program become Integrated Care Delivery System (ICDS) participants in the Dual Demonstration program. This population covers a significant amount of long-term services and support (LTSS) including nursing facility, home care, and HCBS waiver services.

We completed section I of this report for MLTSS and other medical services.

B. RATE DEVELOPMENT STANDARDS

i. Capitation rate structure

The MyCare rate structure for CY 2020 did not change from the 2019 rate structure. Rates continue to vary by region consistent with current geographic definitions. The NFLOC rate cell continues to reflect a composite of the Institutional, Community Waiver 18 – 44, Community Waiver 45 – 64 and Community Waiver 65+ population groups. The NFLOC rate cell will be adjusted by the MEMA on a semi-annual basis. The Community Well population groups includes three separate rate cells: Community Well 18 – 44, Community Well 45 – 64, and Community Well 65+ for a total of four MyCare rate cells.

Community Well

The Community Well category represents eligible dual members who do not meet the NFLOC standard (including the transition rules) as described later in this section. Within the Community Well category, capitation rates vary by contracting region and the following age groups: 18 - 44, 45 - 64 and 65+.

NFLOC

The NFLOC category represents MyCare-eligible members who are enrolled in the MyCare Waiver or covered as a long-term nursing facility (NF) resident (i.e. Institutional population group).

MyCare Waiver enrollees

- An individual who enrolls in the MyCare Waiver will be assigned to the NFLOC rate cell at the beginning of the month following enrollment in the waiver or in the current month if enrollment begins on the first day of the month.

Institutional Population

- An individual must have 100 or more consecutive days billed as NF services based on combined Medicare and Medicaid days to be considered a long-term resident of a NF and included in the Institutional population group.
- Gaps in NF care of 15 days or less per discharge count toward the consecutive day requirement.
- Any days that a member spends in an inpatient hospital setting, once already admitted to a NF, count toward the 100-day requirement.
- Hospice Room and Board days count toward the 100 consecutive day requirement.

Once a Medicaid recipient achieves the one-hundredth NF day (regardless of payer), the member will be assigned to the NFLOC rate cell in the subsequent month and the plan would then be paid the higher rate associated with this population.

NF residents that have been in a NF for 100 or more days immediately preceding that member's enrollment in the MyCare program will be classified into the NFLOC rate cell on the first day of enrollment.

For the NFLOC rate cell, there is a single rating category for each contracting region. The rates are developed using data from the following NFLOC population groups: Institutional, Community Waiver 18 - 44, Community Waiver 45 - 64 and Community Waiver 65+. Current enrollment in MyCare was used as a basis for the projected enrollment distribution by population group for CY 2019. The composite NFLOC rates reflect the anticipated mix of NFLOC members achieved through effective managed care activities.

Transition Rules

Members who had met the criteria for inclusion in the NFLOC rate cell, but later do not, will be transitioned to the Community Well category. The MCOP will continue to receive the NFLOC capitation rate for three full months following the change in categorization. Beginning with the fourth month, the plan will receive the Community Well capitation rate. For members who transition from Community Well to a nursing facility, the member will be assigned to the NFLOC rate cell in the month following the member's one-hundredth day. Members who transition from Community Well to the MyCare waiver will be assigned to the NFLOC rate cell in the month immediately following transition.

C. APPROPRIATE DOCUMENTATION

i. Rate certification and supporting documentation for MLTSS

(a) Capitation rate structure

The blended structure for the NFLOC rate cell, along with the rationale and payment methodology are discussed in a previous section.

(b) Methodology

The structure, rationale, and payment methodology are discussed in a previous section.

(c) Other Payment Structures

The structure, rationale, and payment methodology are discussed in a previous section.

(d) Utilization and unit cost effect

The assumed utilization impact of ongoing transitions from the institution to the community waiver setting on projected trends for waiver services are discussed in a previous section.

(e) Managed care effect

The blended nature of the NFLOC rate cell encourages MCOPs to manage the mix of the population towards lower cost settings. This is the basis for efficiencies in LTSS programs. This transition between settings (e.g. nursing facility to HCBS waiver services) is gradual in nature and is not an immediate transition. Most often, individuals that are in a nursing facility for a long period of time have lost their community supports and it becomes difficult to change the setting away from a nursing facility. Therefore, MCOPs will need to seek individuals that are newer to LTSS benefits and avoid or delay nursing facility placement. Because of this, we assumed gradual increases in HCBS percentages and decreases in nursing facility percentages. Our assumption for CY 2020 is that the percentage of NFLOC individuals in a nursing facility will be reduced by 0.5% by the end of the year. This is a decrease from the 1% reduction assumed in CY 2019 as we have observed this member transition between care settings slow down during the CY 2018 base period and through the first half of 2019, but there remains a continued expectation for reasonable managed care efficiency. This assumes MCOPs will transition these individuals to the community waiver setting.

ii. Non-benefit costs

The non-benefit costs vary by population group and are appropriate for the MLTSS benefits and services.

iii. Experience and assumptions

A previous section details the experience and assumptions employed for the LTSS and non-LTSS services included in the MyCare program.

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 2020 actuarially sound capitation rates for the MyCare Ohio Program (MyCare). 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 MCOPs in the development of the calendar year 2020 capitation rates. Milliman has relied upon ODM and the MCOPs 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 July 12, 2019.

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: 2020 Rate Change Summaries

Ohio Department of Medicaid
MyCare Ohio Opt-In Program
Capitation Rates Effective January 1, 2020
Rate Change Summary

Region: Statewide

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	329,052	$ 3,785.70	$ 3,849.20	1.7%
Community Well 18-44	164,244	344.92	$ 275.68	(20.1%)
Community Well 45-64	269,280	394.94	$ 363.08	(8.1%)
Community Well 65+	238,620	448.34	$ 380.59	(15.1%)
Total	**1,001,196**	**$ 1,513.86**	**$ 1,498.66**	**(1.0%)**

Region: Central / Southeast

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	53,328	$ 4,332.13	$ 4,484.97	3.5%
Community Well 18-44	22,812	433.71	319.88	(26.2%)
Community Well 45-64	37,464	548.79	463.70	(15.5%)
Community Well 65+	39,180	591.49	502.56	(15.0%)
Total	**152,784**	**$ 1,863.10**	**$ 1,855.78**	**(0.4%)**

Region: East Central

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	55,020	$ 3,339.81	$ 3,322.68	(0.5%)
Community Well 18-44	21,108	287.27	256.30	(10.8%)
Community Well 45-64	33,096	351.73	333.62	(5.1%)
Community Well 65+	28,068	423.18	380.70	(10.0%)
Total	**137,292**	**$ 1,553.90**	**$ 1,529.23**	**(1.6%)**

Region: Northeast

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	73,248	$ 3,936.98	$ 4,048.59	2.8%
Community Well 18-44	44,916	364.14	272.26	(25.2%)
Community Well 45-64	74,592	375.55	360.29	(4.1%)
Community Well 65+	77,088	402.72	370.13	(8.1%)
Total	**269,844**	**$ 1,348.15**	**$ 1,349.62**	**0.1%**

Ohio Department of Medicaid
MyCare Ohio Opt-In Program
Capitation Rates Effective January 1, 2020
Rate Change Summary

Region: Northeast Central

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	28,584	$ 3,794.17	$ 3,671.65	(3.2%)
Community Well 18-44	14,016	322.53	244.58	(24.2%)
Community Well 45-64	24,396	366.55	310.30	(15.3%)
Community Well 65+	20,976	413.65	338.57	(18.2%)
Total	**87,972**	**$ 1,484.47**	**$ 1,398.75**	**(5.8%)**

Region: Northwest

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	30,600	$ 3,649.39	$ 3,709.64	1.7%
Community Well 18-44	17,604	285.95	289.31	1.2%
Community Well 45-64	29,580	343.05	365.23	6.5%
Community Well 65+	19,272	360.80	312.34	(13.4%)
Total	**97,056**	**$ 1,378.65**	**$ 1,395.39**	**1.2%**

Region: Southwest

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	51,552	$ 3,807.04	$ 3,928.49	3.2%
Community Well 18-44	28,824	328.93	272.66	(17.1%)
Community Well 45-64	45,312	380.52	348.63	(8.4%)
Community Well 65+	35,316	443.05	365.04	(17.6%)
Total	**161,004**	**$ 1,482.14**	**$ 1,484.87**	**0.2%**

Region: West Central

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	36,720	$ 3,435.48	$ 3,460.22	0.7%
Community Well 18-44	14,964	354.37	264.81	(25.3%)
Community Well 45-64	24,840	394.65	334.58	(15.2%)
Community Well 65+	18,720	513.28	314.86	(38.7%)
Total	**95,244**	**$ 1,583.99**	**$ 1,524.79**	**(3.7%)**

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

© 2019 Milliman, Inc. All Rights Reserved. The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Materials may not be reproduced without the express consent of Milliman.

MILLIMAN CLIENT REPORT

Calendar Year 2020 MyCare Ohio Provider Agreement Rate Certification Summary

Opt-Out Capitation Rates

January 1, 2020 through December 31, 2020

Ohio Department of Medicaid

December 11, 2019

Jeremy D. Palmer, FSA, MAAA
Principal and Consulting Actuary

Marlene T. Howard, FSA, MAAA
Principal and Consulting Actuary

Jason P. Melek, FSA, MAAA
Consulting Actuary

Milliman

Table of Contents

INTRODUCTION & EXECUTIVE SUMMARY **1**

BACKGROUND 1

SECTION I. MEDICAID MANAGED CARE RATES **2**

1. GENERAL INFORMATION 2
2. DATA 4
3. PROJECTED BENEFIT COST AND TRENDS 13
4. SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT 18
5. PROJECTED NON-BENEFIT COSTS 20
6. RISK ADJUSTMENT AND ACUITY ADJUSTMENTS 23

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS **24**

1. MANAGED LONG-TERM SERVICES AND SUPPORTS 24

LIMITATIONS **27**

APPENDIX 1: 2020 RATE CHANGE SUMMARIES

Introduction & Executive Summary

This document is an abridged version of the file titled "Calendar Year 2020 MyCare Ohio Capitation Rate Certification: Opt-Out Capitation Rates" dated December 6, 2019. Please refer to the certification report for a complete version of the calendar year 2020 MyCare Opt-Out capitation rate development documentation.

BACKGROUND

The Ohio Department of Medicaid (ODM), along with CMS and the MyCare Ohio plans (MCOPs), provide benefits under the MyCare Ohio (MyCare) program in targeted geographic areas. MyCare is Ohio's managed care program for the dual eligible (Medicare-Medicaid) population. Contracted MCOPs are required to provide covered services to eligible individuals through either the joint Medicare-Medicaid financial alignment initiative (Opt-In) or the Medicaid managed care program for dual eligible individuals (Opt-Out). Enrollees who select the Opt-In program become Integrated Care Delivery System (ICDS) participants in the Dual Demonstration program.

This letter provides documentation for the development of the calendar year (CY) 2020 actuarially sound capitation rates for Opt-Out individuals.

Section I. Medicaid managed care rates

1. General information

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

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

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

- Actuarial standards of practice (ASOPs) applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective as of January 1, 2020.
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" is defined as in ASOP 49:

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

A. RATE DEVELOPMENT STANDARDS

i. Annual basis

The capitation rates are effective for the one year rate period from January 1, 2020 through December 31, 2020.

ii. Differences among capitation rates

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation associated with the covered populations.

iii. Cross-subsidization of rate cell payment

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

[1] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

iv. Minimum medical loss ratio

The capitation rates were developed such that the MCOPs are reasonably expected to achieve a medical loss ratio greater than 85 percent, which includes provisions for non-benefit costs that are appropriate and attainable.

B. APPROPRIATE DOCUMENTATION

i. Documentation of required elements

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

2. Data

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

A. APPROPRIATE DOCUMENTATION

i. Requested data

As the actuary contracted by ODM to provide consulting services and associated financial analyses for many aspects of the MyCare program (and not limited to capitation rate development), Milliman intakes and summarizes eligibility and expenditure data on a monthly basis using vendor files provided by ODM. Additionally, we receive the cost report data in Microsoft Excel files that the MCOPs submit to ODM on a cumulative quarterly basis, as well as final calendar year versions at each year end that include three months of claims run-out. As such, there is no separate data request from Milliman to the state specifically related to the base data for the capitation rate development. We relied on the CY 2018 encounter data for the Opt-Out program as the base data for the CY 2020 capitation rate development. The remainder of this section details the base data and validation processes utilized in the CY 2020 capitation rate development.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The CY 2018 encounter data for the Opt-Out program served as the primary data source for the CY 2020 capitation rate development for the MyCare Opt-Out program.

The following data sources were utilized to inform adjustments to the plan-submitted encounter data:

- Historical MyCare eligibility files provided by ODM;
- Annual MyCare cost report data submitted by the MCOPs;
- Re-priced inpatient and outpatient hospital claims experience provided by ODM;
- Fee-for-service (FFS) data for dual eligibles;
- CY 2018 Survey submissions completed by each MCOP; and,
- Statutory financial statement data.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during CY 2018. The encounter data used in our rate development process reflected encounters paid through March 31, 2019, consistent with the basis of the annual cost report data. The annual cost report data reflects claims paid through March 31, 2019.

For the purposes of trend development and analyzing emerging population enrollment patterns and claims experience, we also reviewed encounter experience from CY 2016 through the first half of CY 2019. Cost report and encounter data was provided by ODM.

For the purpose of analyzing inpatient and outpatient hospital reimbursement changes, ODM provided hospital encounter data (re-priced to ODM's fee schedule) for inpatient and outpatient hospital services incurred during CY 2018.

We also summarized statutory financial statement data from CY 2017, CY 2018, and the first half of CY 2019. Financial statement data was summarized using MCOP annual cost report data and subsequently reconciled using S&P Global.

(iii) Data sources

The historical encounter data experience used for this certification is submitted by the five MCOPs on an ongoing basis. This data is stored in ODM's Medicaid Information Technology System (MITS). Medicaid

enrollment and encounter data stored in MITS was provided to us for the purposes of developing the CY 2020 capitation rates.

CY 2018 annual cost report data was also provided to us. The cost report data was submitted to ODM and Milliman by each of the five MCOPs in Microsoft Excel files. MCOPs submit cost reports on a cumulative quarterly basis, as well as final calendar year versions at each year end that include three months of claims run-out.

(iv) Sub-capitation

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

Encounter Data: MCOPs 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. The MCOPs provided additional information related to sub-capitated services through their CY 2018 MCOP Survey submissions. These submissions provide insight into areas where a sub-capitated arrangement is present yet the claims are not "shadow priced" in the submitted encounter data. We relied on this information for the purposes of properly identifying sub-capitated MCOP encounter data.

Cost Report: We relied on the separate reporting of non-sub-capitated and sub-capitated experience by the MCOPs in the medical cube worksheets of the CY 2018 cost reports. In the MCOP cost reports, sub-capitated expenditures represent the amounts paid by MCOPs for sub-capitated services, rather than "shadow priced" claims as illustrated in the CY 2018 encounter data.

(b) Availability and quality of the data

(i) Steps taken to validate the data

The base experience used in the capitation rates relies on cost report and encounter data submitted to ODM by participating MCOPs. Managed care eligibility is maintained in MITS by ODM. The actuary, the MCOPs, 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 MCOPs 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 MCOP performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. ODM's contract with the MCOPs stipulates encounter data specific submission and quality standards. Additionally, we perform independent analysis of encounter data and cost report data to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by either us or ODM.

Completeness

MyCare Encounter and Eligibility Data

ODM applies several measures to the MCOP-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 MCOP's fully adjudicated claims file not present in the ODM encounter data files; and,
- Percentage of encounters in the ODM encounter data files not present in the MCP's fully adjudicated claims file.

We also summarize the encounter data to assess month to month completeness of the encounter data. These measures include:

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

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

The CY 2018 MyCare Opt-Out encounter data used in the development of the rates was paid through March 31, 2019. As noted in this report, claims completion is applied to the encounter data for estimated CY 2018 claims paid after March 31, 2019.

Cost Report Data

MCOPs submit quarterly and year-end annual cost report data to ODM. We review each MCOP's quarterly and annual cost reports to identify large data variances, incomplete data, and other reporting issues. These issues are provided to each MCOP 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 MCOP and reconciled to the MCOP's audited NAIC financial statement information. The year-end annual cost report is completed by the MCOPs using claims incurred in the CY 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

We reviewed the accuracy of the encounter data by comparing expenditures to outside data sources including MCOP cost report submissions along with NAIC financial statement information. We also reviewed the encounter data to ensure each claim is related to a covered individual and a covered service. 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 MCOP and service category combinations that may have unreasonable reported data.

Cost Report Data

As stated in the Completeness section, MCOPs submit quarterly and annual cost-report data to ODM. In terms of accuracy measures, the process of submitting both quarterly and annual reports identifies unreasonable or inconsistent values in the data among cost report submissions. In addition to utilization and cost metrics, financial measures such as medical loss ratio, underwriting margin, and administrative loss ratio are tracked across plans and populations. These metrics enable efficient identification of potential cost allocation issues. We also evaluated the cost report expenditures in relation to statutory financial statements for each MCOP to ensure expenditure differences were reasonable.

Consistency of data across data sources

We performed a detailed review of the encounter data used in the development of capitation rates effective January 1, 2020. Assessing the encounter data for consistency with the MCOP cost reports was a vital part of the rate development process.

We reviewed PMPM values by rate cell and region for CY 2018 encounter data and CY 2018 cost reports. Experience was reviewed for non-sub-capitated services, sub-capitated services, and in aggregate. Aggregate expenditures in the encounter data were approximately 5% less than aggregate expenditures in the cost report data (prior to any data quality adjustment). Differences between the encounter data and cost report expenditures were generally attributable to service categories where a large portion of the expenditures were sub-capitated, due to differences in the reporting of sub-capitated expenditures between the two data sources (shadow-priced versus ceded premium).

(ii) Actuary's assessment

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

We find the encounter data used as the base data source for the development of the 2020 capitation rates to be of appropriate quality and suitable for the purpose of developing actuarially sound rates (subject to the data concerns and resolutions indicated in the Data concerns section below). The resulting base data PMPM expenditures for CY 2018, after the application of the adjustments, is within approximately 1.3% of the CY 2018 cost report PMPM expenditures. The encounter data additionally appears reasonable in relation to Medicaid dual eligible managed care industry experience.

(iii) Data concerns

Through discussions with ODM and various data analyses, we were made aware of and confirmed adjustments which were necessary to apply to the CY 2018 encounter data as follows:

- Apply missing encounter data adjustments as provided by the MCOPs in the 2018 MCOP Survey. Remove non-state plan services from cost report and encounter expenditures.
- Remove delegated admin from cost report sub-capitated expenditures, apply data quality adjustment to encounter data as warranted. State both cost report and encounter expenditures on a net basis for TPL and F&A.
- Remove enrollment counts and claims for members with IMD stays greater than 15 days in a calendar month.

We have not identified any material concerns with the quality or availability of the encounter data, other than those listed above.

(c) Appropriate data

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

FFS claims and enrollment were not used as the primary data source for this certification. Rather, the FFS data was used to assist with the development and verification of program and pricing adjustments and other modeling assumptions. The FFS data used to supplement the CY 2020 rate development reflects historical experience and covered services closely aligned with the MyCare program.

(ii) Use of managed care encounter data

The CY 2018 Opt-Out encounter data is the primary data source used in the development of the capitation rates.

(d) Reliance on a data book

Development of the capitation rates did not rely on a data book or other summarized data source. We were provided with detailed claims data for all covered services and populations. We created data books summarizing CY 2018 encounter data, which were shared with ODM and participating MCOPs.

iii. Data adjustments

Capitation rates were developed primarily from CY 2018 encounter data. Adjustments were made to the base experience for data quality, completion, reimbursement changes, regional stratification, and other program adjustments.

(a) Credibility adjustment

In total, the statewide MyCare Opt-Out program experience was fully credible. While we did not apply an explicit credibility adjustment to the data, we did apply regional factors to the base data in the development of the Opt-Out capitation rates at the region and rate cell level.

To mitigate any credibility concerns at the regional level and to preserve potentially proprietary MCOP information in regions where only two MCOPs are present, we developed the regional factors to stratify the statewide Opt-Out experience into regional summaries. These factors were primarily informed by the combined CY 2018 Opt-Out and Opt-In encounter data.

(b) Completion adjustment

The capitation rates are based on CY 2018 Opt-Out program experience. Encounter data is paid through March 31, 2019. Completion factors were developed by summarizing encounter data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability, using Milliman's Robust Time-Series Analysis System (RTS)[2].

First, we stratified the data by category of service. Claims for each of these population-service category stratifications were analyzed and formed into lag triangles by paid and incurred month. Claim completion factors were developed for each month of the base experience period, based on historical completion patterns. Completion factors developed through the use of encounter data were compared to MCOP reported IBNP liability estimates in the CY 2018 MCOP Cost Reports. Based on our review of historical claim payment patterns and prior rate development analyses, we elected to apply completion adjustments based on our calculated IBNP liabilities rather than the IBNP liabilities reported by the MCOPs.

The monthly completion factors were applied to CY 2018 experience to estimate the remaining claims liability for the calendar year.

(c) Errors found in the data

Through discussions with ODM and our independent review of the data, we applied adjustments to the CY 2018 encounter data to create the base data for the capitation rate development.

(d) Program change adjustments

The subsectiions below include details related to the program and reimbursement changes that have occurred in the MyCare program since January 1, 2018, the beginning of the base experience period used in the capitation rate development.

Calendar Year 2017

IMD as an "In Lieu of" Service. Effective July 1, 2017, ODM began permitting the use of IMDs as an "in lieu of" service for the 21 to 64-year-old population for up to 15 days per month. This program change was implemented in compliance with the conditions outlined in the final Medicaid managed care regulations. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD. The unit cost for IMD services was developed based on the cost per admit of Inpatient Psychiatric/SA services for non-teaching hospitals for the Medicaid Managed Care (MMC) aged, blind, and disabled (ABD) adult population.

Calendar Year 2018

Serious Mental Illness (SMI) Health Home.

Effective July 1, 2018, ODM discontinued its SMI Health Home program. These services, which were previously billed under HCPCS S0281, were primarily utilized by members residing the Northwest and Southwest regions. We reviewed first-half (1H) and second-half (2H) 2018 utilization for the providers who previously rendered S0281, and observed material increases in utilization for services other than S0281 following the sunset of the SMI Health Home. For these codes, we calculated the impact of 1H 2018 utilization increasing to levels consistent with 2H 2018.

[2] The Robust Time Series Reserve Analysis System (RTS) is a model designed to assist an actuary in performing an Incurred But Not Paid (IBNP) reserving analysis. The RTS is unique because it contains functionality that: provides reasonable best estimates in spite of contaminated data, provides reasonable margins for the total reserve, independently models shock claims, and provides forecasts of future cash flows. This methodology forecasts future claim runout using time series forecasting which employs the interrelationship between claim payments during the first three months of claim payments for each incurred month.

Nursing Facility Per Diem Updates.

In the MyCare program, the plans are required to pay the NFs at the same rates used by ODM for FFS claims. ODM currently updates the NF payment rates and acuity scores on a semi-annual basis. An adjustment was applied to reflect the regional impact of the semi-annual NF per diem update, effective July 1, 2018. We estimated the impact of the semi-annual per diem update at the population group and region level based on NF per diem updates by provider.

Ventilator-Dependent Nursing Facility Rate Change.

Effective July 1, 2018, ODM began reimbursing nursing facilities for the higher costs associated with caring for individuals who are ventilator-dependent at an elevated per diem rate equal to $645.00. We estimated the impact of the NF per diem update at the population group level based on repricing the average NF per diem to the higher ventilator-dependent per diem for individuals identified as ventilator-dependent.

Calendar Year 2019

Ventilator-Dependent Nursing Facility Rate Change.

Effective January 1, 2019 ODM updated the nursing facility per diem rates to $754.22 for individuals who are ventilator-dependent and to $905.06 for individuals who are weaning off ventilator dependence. Effective July 1, 2019, ODM increased the nursing facility per diem rates to $819.49 for individuals who are ventilator-dependent and to $983.39 for individuals who are weaning off ventilator dependence. We relied on information from ODM related to the assumption that approximately 29% of individuals will have attempts to wean of ventilator dependence, and approximately 23% of those attempts are estimated to be successful. Based on this information, we estimated the impact of the NF per diem update at the population group level based on repricing the average CY 2019 projected NF per diem to the ventilator-dependent per diem for individuals identified as ventilator-dependent.

Home Delivered Meals Fee Change

Effective January 1, 2019, ODM implemented a reimbursement change for home delivered meals which aligns the rates for all eligibility groups in managed care and FFS. The reimbursement change included separate rates for standard meals at $6.50, and alternate meals for specific dietary needs at $8.68. We estimated the impact to waiver service expenditures associated with the home delivered meals fee changes.

Emergency Response Systems Fee Change

Effective January 1, 2019, ODM implemented a reimbursement change for emergency response systems which aligns the rates for all eligibility groups in managed care and FFS. The revised reimbursement rate for emergency response systems installation and monthly rental increased to $32.95. We estimated impact to waiver service expenditures at the population group level associated with the emergency response systems fee change.

Behavioral Health Fee Schedule Changes.

Effective August 1, 2019, ODM implemented policy and payment rate changes for the following behavioral health (BH) services, reflected in Ohio Administrative Code (OAC) rule 5160-27-03, which will result in an increase to projected provider reimbursement:

- Crisis Services: Crisis services for both Mental Health (MH) and Substance Use Disorder (SUD) treatment received a 30% fee increase for certain impacted billing codes.
- Group Therapy: Group Psychotherapy, MH Therapeutic Behavioral Services (TBS), and SUD Counseling services received a 30% fee increase for certain impacted billing codes.
- Evaluation and Management (E&M) Services: E&M services and diagnostic psychiatric evaluations provided by Certified Nurse Practitioners, Clinical Nursing Specialists, and Physician Assistants at BH providers are subject to reimbursement at 100% of the Medicaid maximum rate, which is an increase from the previous policy of 85%.

- Individual TBS: Licensed clinicians employed by BH agencies are allowed to render TBS in an individual setting. We anticipate providers who were previously rendering Community Psychiatric Supportive Treatment (CPST) will now provide TBS at a higher reimbursement rate.

To estimate the impact of the above items, we used CY 2018 BH encounters and FFS claims along with CPT and HCPCS-level rate increase assumptions provided by ODM.

Calendar Year 2020

Inpatient Reimbursement Changes.

Effective January 1, 2020, ODM will rebase its inpatient hospital base rates through the continued use of All Patients Refined Diagnosis Related Groups (APR DRG). This includes revised APR DRG relative weights along with updated hospital base rates.

Outpatient Reimbursement Changes.

Effective January 1, 2020, ODM will rebase its outpatient hospital payments through the continued use of the Enhanced Ambulatory Patient Grouping System (EAPG). This includes accommodation of the latest EAPG grouper version, updated EAPG relative weights, and updated base rates by hospital.

Nursing Facility Reimbursement Changes.

In the MyCare program, the plans pay the NFs at the same rate used by ODM for FFS claims. ODM updates nursing facility payment rates and acuity scores on a semi-annual basis. We applied adjustments to reflect the impact of the semi-annual per diem updates which were effective January 1, 2019, July 1, 2019, and anticipated for January 1, 2020. Adjustments were applied to the nursing facility and hospice room and board categories of service, and vary based on differences in base nursing facility experience by population group and region.

Waiver Rate Increases.

ODM anticipates increasing the reimbursement for certain waiver nursing and personal care services. Using CY 2018 encounter data, we evaluated the impact of this program adjustment by estimating paid claim amounts under 2018 ODM reimbursement and 2020 ODM reimbursement levels to determine the percentage impact to waiver services.

Other Fee Schedule Changes.

We reviewed other known fee schedule changes for changes effective between the start of CY 2018 and CY 2020.Through the use of fee schedules provided by ODM, as well as 5160-1-60 Appendix DD, we estimated the impact of these fee schedule changes and applied rating adjustments to impacted categories of service. Using CY 2018 encounter data, we evaluated the impact of this program adjustment by estimating paid claim amounts under 2018 ODM reimbursement and 2020 ODM reimbursement levels to determine the percentage impact to applicable services. The impact of these reimbursement changes was calculated net of the impact of the change to the Medicaid maximum payment methodology.

Population Morbidity Changes.

We applied adjustments to account for estimated population morbidity differences between calendar year 2018 and calendar year 2020. Adjustments were applied to account for known population changes based on data provided by ODM. Items considered when developing these adjustments are outlined below.

- **Duplicate Member IDs**. We were informed of the potential for duplicate member IDs in the vendor file eligibility information we received. We removed member months associated with duplicate member IDs to the extent these members remained in CY 2018.
- **Deceased Members.** ODM provided member identification information for individuals who have been identified as deceased, but were not reported as deceased in the encounter data. We reduced the member months from the eligibility underlying the encounter data for enrollment reported after the date of death of a member.

- **Spenddown Population.** Between July and October 2018, the former spenddown population began enrolling in the MyCare program. We received a listing of former Spenddown recipient IDs from ODM, and utilized this information to develop enrollment and morbidity impacts associated with the introduction of this population.
- **Specialized Recovery Services (SRS) Population.** Beginning October 2018, members eligible for Medicaid under the 1915(i) waiver were enrolled in mandatory managed care. We received a listing of SRS recipient IDs from ODM, and utilized this information to develop enrollment and morbidity impacts associated with the introduction of this population.
- **Enrollment Backlog**. ODM identified a backlog of individuals eligible for the MyCare program that were enrolled in the fee-for-service Medicaid program. We received a listing of the enrollment backlog recipient IDs from ODM, and utilized this information to develop the estimated impact associated with the introduction of this population. We anticipate that the morbidity of this population will be consistent with the morbidity of the existing MyCare program, and will continue to monitor this population as emerging experience becomes available.

We estimated the morbidity impact at the regional level for the anticipated new populations as follows:

- On a statewide basis, we summarized CY 2018 FFS claims experience for the new populations using member IDs provided by ODM, and compared their costs to the CY 2018 base data PMPM for the base population, to develop a cost relativity. We estimated the cost relativities for the following service groupings:
    - Non-behavioral health acute care services
    - Behavioral health services
    - Long-term care services

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 MyCare program during CY 2020 that are not fully reflected in the CY 2018 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 MCOPs. *We defined a program adjustment to be 'material' if the total benefit expense for any individual rate cell is impacted by more than 0.1%.* In addition, program adjustments that were determined to be material in prior rate setting activities, but that may have an immaterial impact in the 2020 MyCare capitation rate development, are outlined in the program adjustment sections above. The following is a list of program adjustments deemed immaterial based on our review of the experience data and policy change.

- **APRN Prescribing.** There was a provision in MCDCD49 allowing an Advanced Practice Registered Nurse (APRN) who is certified in psychiatric mental health by a national certifying organization to prescribe atypical antipsychotics and antidepressant drugs without going through prior authorization. This provision already exists for psychiatrists. Given the existing high rate of prescribing for "preferred" agents, we do not anticipate a material shift in volume to more expensive agents.
- **Laboratory Contract and Community SUD Treatment Providers.** Effective January 1, 2019, substance use disorder (SUD) providers (provider type 95) with appropriate CLIA certifications will be able to perform on-site laboratory services. Based on information provided by ODM, we do not anticipate that this program adjustment will result in a material increase in laboratory service expenditures.
- **Pharmacist Administered Injectables.** Effective January 1, 2019, pharmacists administering injection drugs shall be provided an administration fee at the point-of-sale from the MCOPs (as allowed under Ohio Administrative Code (OAC) rule 4729-5-40). Based on information provided by ODM, we do not anticipate incremental costs associated with this program change.

Each of the program adjustments listed above were determined to be immaterial on a stand-alone basis (i.e., impacted the rates by less than 0.1%). We evaluated the composite impact of all of the immaterial items listed above to assess whether an aggregate impact should be applied in the CY 2020 rate development process.

Based on this analysis, the impact of immaterial program adjustments is immaterial on a composite basis (i.e., impacted the rates by less than 0.1%), so no further adjustments were applied.

(e) Exclusion of payments or services from the data

The following adjustments were made to the base experience data to reflect pharmacy rebates, third party liability recoveries, and non-encounter claims payments.

Services excluded from initial base data summaries

Non-State Plan Services

We excluded all services included in the encounter data that do not reflect approved state plan services (nor are an approved in-lieu-of service).

Institution for Mental Disease (IMD) Stays Greater than 15 Days

We excluded all costs for enrollees aged 21 to 64 associated with an IMD stay of more than 15 days in a calendar month. This exclusion included any other costs outside of the IMD for any services delivered during the time an enrollee was in the IMD for more than 15 days.

Third Party Liability/Fraud and Abuse

In addition to actual cost avoidance reflected in the encounter data, we estimated additional third party liability (TPL) and fraud recoveries based on data available in CY 2018 cost reports and MCOP surveys.

Adjustments made to base data

Upon review of 2018 cost reports and MCOP surveys, we adjusted the base data for the following items:

- Pharmacy Rebates
- Net Reinsurance

3. Projected benefit cost and trends

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

A. RATE DEVELOPMENT STANDARDS

i. Final Capitation Rate Compliance

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). Non-state plan services provided by the MCOPs have been excluded from the capitation rate development process. Effective July 1, 2017, ODM began permitting the use of IMDs as an in-lieu-of service for the 21 to 64-year-old population for up to 15 days per month.

ii. Basis for Variation in Assumptions

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

iii. Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the covered populations.

iv. In Lieu Of Services

As noted earlier, ODM began permitting the use of IMDs as an in-lieu-of service effective July 1, 2017. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

v. Benefit expenses associated with members residing in an IMD

We reviewed benefit costs for enrollees aged 21 to 64 during the base experience period to identify costs associated with an Institution for Mental Diseases (IMD) stay of more than 15 days in a month and any other MCOP costs for services delivered in a month when an enrollee had an IMD stay of more than 15 days. These costs were identified and removed from the encounter data. In addition, as noted above we did not use the unit cost of the IMD as an in-lieu-of service, and instead utilized the unit cost for that of existing state plan providers.

B. APPROPRIATE DOCUMENTATION

i. Projected Benefit Costs

This section provides the documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

ii. Development of Projected Benefit Costs

(a) Description of the data, assumptions, and methodologies

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

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

The capitation rates were primarily developed from historical expenditure and enrollment data experience in CY 2018. This data consists primarily of CY 2018 incurred encounter data that has been submitted by the MCOPs and adjusted for known missing claims reported in the CY 2018 MCOP Survey submissions. Additionally, CY 2018 MCOP cost report data has been utilized to supplement cost information for certain service categories where the encounter data PMPMs did not appear to be reasonable.

Step 2: Apply base data adjustments to cost summaries

The base experience period was adjusted for the items previously outlined. The development of the regional stratification factors applied to the statewide Opt-Out base data encompassed data smoothing techniques for low credibility populations and to preserve potentially proprietary MCOP information at the regional level. For example, we evaluated the grouping of nursing facility level of care (NFLOC) populations, Community Waiver populations, and/or Community Well populations as appropriate to develop the regional stratification factors applied to each population. We utilized relativities observed in the CY 2018 encounter data and the CY 2018 cost reports in composite for the MyCare Opt-In and Opt-Out programs to develop the regional stratification factors. The factors were developed to maintain budget neutrality across the base data experience.

We developed region factors by major service category at the rate cell level. For retrospective program adjustment factors, the adjustments were developed at either the statewide total level, or at the population and/or regional level as appropriate.

Step 3: Adjust for prospective program and policy changes and trend to calendar year 2020

Adjustment factors were developed and applied to the CY 2018 base experience to reflect known policy and program changes that have occurred or are expected to be implemented in calendar years 2018 through 2020. Full documentation of currently known items that were considered in the rate development is provided in this report. The adjusted PMPM values from the base experience period were trended forward to the midpoint of the contract period (July 1, 2020). Adjustments were applied to the PMPM values to reflect program changes between the base period and effective rate period. The resulting PMPMs establish the adjusted claim cost by population for the contract period. Consistent with step 2, program adjustment and trend factors were developed at either the statewide total level, or at the population and/or regional level, as appropriate.

Step 4: Incorporate non-benefit items and adjustments

The CY 2020 capitation rates include an allowance for non-benefit cost items. This includes care management costs, administrative allowance, Health Insuring Corporation (HIC) tax, HIC Franchise Fee, and provision for margin. The provision for margin includes items such as cost of capital, risk mitigation, contingency, underwriting gain, and profit.

Note that MCOPs will receive a separate payment from ODM for the Health Insurer Fee (HIF) as appropriate.

Step 5: Composite nursing facility level of care (NFLOC) rating cell

The Institutional and Community Waiver populations were combined to create the NFLOC rates by region. We applied a 0.5% rebalancing shift between NFLOC beneficiaries residing in NFs and a community setting to the current composite enrollment in MyCare to develop the projected enrollment distribution for 2020.

This step does not apply to the Community Well capitation rate cells.

Other material adjustments - managed care efficiency

The base data represents the MyCare managed care population in CY 2018, and the projected CY 2020 enrollment represents Opt-Out enrollment as of July 2019, with assumptions for SRS recipients and former spenddown members who enrolled in the Opt-Out program during CY 2019. We expect continued improvement in managed care for the NFLOC population, and therefore applied a 0.5% rebalancing shift between NFLOC beneficiaries residing in NFs and a community setting. We did not apply any further managed care adjustments.

(b) Material changes to the data, assumptions, and methodologies

Material changes to the rate development methodology include:

- The primary base data source has changed from the CY 2017 Opt-Out MyCare encounter data to CY 2018 Opt-Out MyCare encounter data.
- We relied on Opt-In data to supplement Out-Out data primarily for assumptions related to regional factors and non-benefit expenses.

The CY 2020 capitation rate development no longer includes a distribution between crossover and non-crossover services. All material assumptions are documented in this rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis.

(c) Provider Overpayments

To the best of our knowledge, all information related to any payment recoveries not reflected in the base period encounter data was provided to us by the MCOPs in their survey responses, and the CY 2018 base data was adjusted to reflect any such recoveries.

iii. Projected Benefit Cost Trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (CY 2018) to the CY 2020 rating period of this certification. We evaluated prospective trend rates using ODM data, as well as external data sources.

Total benefit cost trends were developed on a PMPM basis consistent with prior years' certifications. The trends are illustrated on a PMPM basis and primarily reflect utilization and mix/intensity of services. ODM-specific policy changes that impact CY 2020 provider reimbursement are handled through the program adjustments previously outlined.

(a) Required elements

(i) Data

The CY 2016 through 2018 MCOP Opt-Out encounter data was the primary source for the development of estimated prospective trend rates.

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. 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.

(ii) Methodology

For internal ODM data, historical per member per month cost data was stratified by month, population, and category of service. The data was normalized for material program adjustments to reflect a consistent reimbursement and covered benefit structure across the historical data period. We used linear and time series regression analyses to project experience during the contract period. Contract period projections were compared to base period experience to determine an appropriate annualized trend. The data was adjusted for completion and the resulting historical trends were summarized as a data point in our process.

(iii) Comparisons

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

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

(iv) Documentation

As discussed previously, 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 MCOP encounter data trend experience due to anomalies observed in the historical trend data. We referred to the sources listed in the prior section as well as considered changing practice patterns, the impact of reimbursement changes on utilization in the MyCare population, and the shifting population mix.

We have not included any outlier or negative trends for the development of the CY 2020 capitation rates.

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

We have reviewed ODM's final report regarding compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as required by 42 CFR 438.3(c)(1)(ii). Results of the analysis indicate full compliance with MHPAEA for both quantitative and non-quantitative treatment limits with no remediation needed that would constitute a program adjustment. Based on the final results, we have not made any rating adjustments to accommodate parity compliance.

v. In Lieu of Services

Effective July 1, 2017, ODM began permitting the use of IMDs as an in-lieu-of service for the 21 to 64-year-old population for up to 15 days per month. This program change was implemented in compliance with the conditions outlined in the final Medicaid managed care regulations. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers. IMD as an in-lieu-of service is contained within the "Inpatient Hospital" service category, and is not included in any other service categories.

vi. Retrospective Eligibility Periods

(a) MCOP responsibility

The MCOPs are responsible for retrospective eligibility periods when the beneficiary was previously enrolled with an MCOP in the MyCare program less than 90 days prior to re-enrolling with an MCOP. ODM provides capitation payments to the MCOPs for beneficiaries meeting this criteria.

(b) Claims treatment

No base data adjustment was required for retroactive eligibility.

(c) Enrollment treatment

Enrollment is treated consistently with claims. We have not adjusted for retrospective eligibility.

(d) Adjustments

As previously mentioned, no explicit adjustment was applied for the CY 2020 rate setting.

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the July through December 2019 rating period. This certification applies to the CY 2020 effective period.

(a) Change to covered benefits

Material changes to covered benefits have been described in a previous section.

(b) Recoveries of overpayments

To the best of our knowledge, all information related to any payment recoveries not reflected in the base period encounter data was provided to us by the MCOPs in their survey responses and the CY 2018 base data was adjusted to reflect any such recoveries.

(c) Change to payment requirements

Material changes to required provider payments have been described in a previous section.

(d) Change to waiver requirements

There were no material changes related to waiver requirements or conditions.

(e) Change due to litigation

There were no material changes due to litigation.

viii. Documentation of Material Changes

The estimated impact of material changes to covered benefits and provider payments have been quantified in program adjustments described in a previous section. This information includes the data, assumptions, and methodology used in developing the adjustment, estimated impact by population, and aggregate impact on the managed care program's benefit expense. Non-material changes to covered benefits or provider payments have also been described in this section of the report.

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate Development Standards

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

ii. Appropriate Documentation

There are no bonuses or incentives offered in the MyCare Opt-Out program.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the withhold arrangement in the MyCare program.

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period and purpose

The withhold arrangement is measured on a calendar year basis. For CY 2020, the percent of withhold amounts repaid to each MCOP for the Opt-Out program will be equal to the percent of withhold the MCOP receives for the dual benefit (Opt-In) members as determined in accordance with the 'CMS Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes'. This document also outlines the CMS core measures evaluated in the withhold analysis performed by CMS.

(ii) Description of total percentage withheld

Withholds constitute 3% of the certified rates for CY 2020. The capitation rates shown in this letter are illustrated before offset for the withhold amount; however, the CY 2020 capitation rates documented in this report are actuarially sound while considering the amount of the withhold not expected to be earned.

(iii) Estimate of percent to be returned

Based on our review of information provided by ODM, as well as the "Ohio Medicare-Medicaid Plan Quality Withhold Analysis Results for Demonstration Year 3" applicable to CY 2017, we believe that a full withhold return is attainable by the MCOPs[3].

(iv) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 3% of capitation revenue indicates that it is reasonable within the context of the capitation rate development and the magnitude of the withhold does not have a detrimental impact on the MCOP's financial operating needs and capital reserves. Our interpretation of financial operating needs relates to cash flow needs for the MCOP to pay claims and administer benefits for its covered population. We evaluated the reasonableness of the withhold within this context by reviewing the MCOP's cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by ODM.

(v) Effect on the capitation rates

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

[3] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReportOHDY3.pdf. Accessed 10/16/2019

(b) Certification of Withhold Arrangement

As previously stated in this report, we believe that a full withhold return is attainable by the MCOPs. Therefore, the rate is certified as actuarially sound without removal of any portion of the withhold.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

This section provides documentation of the risk-sharing mechanisms in the MyCare program.

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

There are no risk-sharing mechanisms in the MyCare Opt-Out program.

(b) Medical Loss Ratio

There are no minimum loss ratio requirements in the MyCare Opt-Out program.

(c) Reinsurance Requirements and Effect on Capitation Rates

MyCare MCOPs are required to maintain minimum reinsurance protection as set out in the Ohio Administrative Code. The 3-way contract for the Opt-In program outlines specific requirements. Opt-Out requirements are consistent with the Opt-In requirements. We have adjusted expenses in the historical period by the net cost of reinsurance (reinsurance premiums less reinsurance recoveries) as reported in the 2018 annual cost report data. Reinsurance recoveries were based on amounts reported in MCOP cost report data.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

This section is not applicable because there are no delivery system or provider payment incentives for the MyCare program as defined by the CMS Rate Setting Guide.

E. PASS-THROUGH PAYMENTS

This section is not applicable because there are no pass-through payments for the MyCare program as defined by the CMS Rate Setting Guide.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR §438.5(e), the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to MCOP operation of the MyCare program.

The remainder of this section provides documentation of the data, assumptions and methodology that we utilized to develop the non-benefit cost component of the capitation rate.

ii. PMPM versus percentage

The non-benefit cost was developed as a percentage of the capitation rate for general administrative costs and margin, and as a PMPM for care management.

iii. Basis for variation in assumptions

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

iv. Health insurance providers fee

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

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

(a) Description of the data, assumptions, and methodologies

Data

The primary data sources used in the development of the CY 2020 non-benefit costs are listed below:

- Annual and first half 2019 cost report data submitted by the MCOPs.
- CY 2018 MCOP Survey completed by each MCOP.
- Statutory financial statement data for each of the MCOPs.

Assumptions and methodology

In developing the administrative costs, we reviewed the CY 2016, through first half 2019 cost reports and found a significant amount of variation in the reporting of administrative expenses between the five MCOPs, both in the magnitude of administrative expenses and in the rate cell allocation methodology utilized. .

Cost report administrative expenses for both the Opt-Out and Opt-In MyCare programs were analyzed by MCOP for reasonableness and completeness of the data provided. For MCOPs with unreasonable administrative expense rate cell allocation, we reallocated their total administrative costs using the rate cell administrative expense distribution of the other MCOPs. This data formed the baseline for projected 2020 administrative expense amounts. Separate administrative expenses amounts were developed for each rating group.

(b) Material changes

Projected non-benefit costs for CY 2020 include a risk margin decrease from 3% in the CY 2019 capitation rates to 2% in the CY 2020 capitation rates. This decrease reflects an assumption of reduced risk related to the maturity of the program, enrollment volume, and the ability to develop capitation rates independently between Opt-In and Opt-Out for the MyCare program.

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

(c) Other material adjustments

There are no other material adjustments applicable to the non-benefit cost component of the capitation rate.

ii. Non-benefit costs, by cost category

(a) Administrative expenses

Administrative expenses have not been developed from the ground up (based on individual components). However, individual components were reviewed within MCOP 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 CY 2020 non-benefit cost allowance is determined as a percentage of the capitation rates before fees and taxes.

(b) Care coordination and care management

Care coordination and care management is calculated on a PMPM basis separately from general administrative expenses in the MyCare program.

AAA Plus Plan Management: Community Waiver Enrollees 60+

MCOPs are required to contract with Area Agencies on Aging (AAAs) to perform core waiver coordination services for members who are 60 years or older and on a 1915(c) waiver. Care management (plan management) for coordination of non-core services must be provided by the plans as well, but is not required to be provided through the AAAs.

Based on discussions with ODM, we assumed a 2.0% increase to the CY 2019 AAA Plus Plan Management PMPM costs for CY 2020.

Plan Management: Other Populations

Neither waiver coordination services nor non-waiver care management services are required to be contracted with the AAAs for the other MyCare populations. Thus, the total care management costs are additionally referenced as plan management costs. Upon review of the total care management costs from the CY 2016 through first half 2019 cost reports, we determined that the care management costs represent approximately half of total administrative expenses for all MCOPs in composite. We determined that a 50% distribution between care management expenses and other administrative expenses, after rebasing of the Community Waiver 60+ costs, would result in a reasonable composite normalized PMPM in comparison to the CY 2018 and first half 2019 cost report data

The care management costs for the Community Waiver 45-64 population were developed as a member weighted average of the Community Waiver 18-44 plan management PMPM and the AAA Plus Plan Management PMPM Costs.

(c) Health insuring corporation franchise fee

Fees and Taxes are loaded to the capitation rates after the application of non-benefit expenses. This includes the Health Insuring Corporation (HIC) Franchise Fee along with the HIC tax. The HIC Franchise Fee consists of a PMPM amount that varies based on an entity's Medicaid member months. The development of the actuarially sound capitation rates includes HIC Franchise Fee (collected by ODM) and HIC tax (collected by the Ohio Department of Insurance) components.

HIC Franchise Fee amounts were developed by MCOP based on projected Medicaid member months for January through June 2020, and then weighted based on regional enrollment by MCOP. As the HIC Franchise Fee is assessed on a state fiscal year basis, we anticipate amending the CY 2020 capitation rates to reflect HIC Franchise Fee amounts applicable to July through December 2020. The HIC tax will remain at 1% of the total capitation rate.

iii. Health insurance providers fee

(a) Whether the fee is incorporated in the rates

As applicable, CY 2020 rates will be amended based on the calculated HIF attributable to ODM premium revenue, consistent with ODM's payment of the HIF in prior years. To the extent the actual paid HIF is less than the calculated HIF, the rates for the MCOP will be amended based on actual paid HIF.

(b) Fee year or data year

The HIF for each insurer is calculated based on the data year. Amended CY 2020 rates will be based on the 2021 HIF attributable to the 2020 data year, as applicable.

(c) Determination of fee impact to rates

As applicable, the calculation of the fee for each MCOP 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 MCOPs subject to the HIF, Form 8963 premium amounts attributable to ODM, data year HIF tax percentage, and adjustments for premium revenue based on benefits described in 26 CFR 57.2(h)(2)(ix) such as nursing home and home health care. Final fee amounts are adjusted for applicable fees and taxes that are applied to ODM capitation rate revenue (documented in the non-benefit expense section of this report).

(d) Timing of adjustment for health insurance providers fee

The 2020 capitation rates will be amended based on any applicable HIF in 2021 attributable to the 2020 data year. We anticipate amending the rates in the last quarter of CY 2021.

(e) Identification of long-term care benefits

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

(f) Application of health insurance providers fee in 2014, 2015, 2016, and 2018 capitation rates

The MCOPs were required to pay the HIF in 2014, 2015, 2016, and 2018. For each year, the initially certified capitation rates were adjusted to include the HIF and associated income tax impacts to reflect the non-tax-deductibility of the HIF.

6. Risk Adjustment and Acuity Adjustments

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

A. RATE DEVELOPMENT STANDARDS

i. Overview

The MyCare rates have been developed as full risk rates. The MCOPs assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract. The regional NFLOC rates will be prospectively adjusted by MCOP to reflect mix differences in the enrolling population between nursing facility and Community Waiver setting of care. This adjustment will be made to the rates prospectively. No additional risk adjustment is planned for this population in CY 2020.

ii. Risk adjustment model

For the prospective member mix, we will continue to employ member enrollment mix adjustment (MEMA). This methodology adjusts the NFLOC capitation rates based on a MCOP's mix of nursing facility and Community Waiver membership.

iii. Acuity adjustments

Acuity adjustments are not applicable to the CY 2020 capitation rates.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data and adjustments

- The MEMA is a budget-neutral adjustment which will be updated January and July of each year.
- October 2019 MyCare Opt-Out enrollment data is anticipated to be used for the January 1, 2020 through June 30, 2020 MEMA development.
- April 2020 MyCare Opt-Out enrollment data is anticipated to be used for the July 1, 2020 through December 31, 2020 MEMA development.

MEMA will account for the variation in HIC Franchise Fee payments by MCOP. MEMA will be applied to the CY 2020 capitation rates less the HIC Franchise Fee and tax amounts. We will then apply MCOP-specific HIC Franchise Fee and tax amounts to the normalized rates on a budget neutral basis. Community Well rate cells are excluded from MEMA; however, they are subject to the HIC Franchise fee. For these rate cells, we will apply adjustments to account for variation in projected HIC Franchise Fee amounts by MCOP.

(b) Risk adjustment model

For the prospective member mix, we will continue to employ MEMA. This methodology adjusts the NFLOC capitation rates based on a MCOP's mix of nursing facility and Community Waiver membership. We will provide full documentation of these results and methodology for MEMA analysis in a separate correspondence.

(c) Risk adjustment methodology

The MEMA adjustment is applied by region for the NFLOC rate cell for each MCOP. Each population group within the NFLOC rate cell is given a weight based on its relative capitation rate compared to the composite NFLOC capitation rate. Each MCOP will receive a calculated MEMA score based on their enrollment of each population group within the NFLOC rate cell. To ensure budget neutrality, the MEMA scores will be normalized to 1.000 for each region. MEMA methodology uses generally accepted actuarial principles and practices.

Section II. Medicaid Managed care rates with long-term services and supports

1. Managed Long-Term Services and Supports

A. COMPLETION OF SECTION I

MyCare is Ohio's managed care program for the dual eligible (Medicare-Medicaid) population. Contracted MCOPs are required to provide covered services to eligible individuals through either the joint Medicare-Medicaid financial alignment initiative (Opt-In) or the Medicaid managed care program for dual eligible individuals (Opt-Out). Enrollees who select the Opt-In program become Integrated Care Delivery System (ICDS) participants in the Dual Demonstration program. This population covers a significant amount of long-term services and support (LTSS) including nursing facility, home care, and HCBS waiver services.

We completed section I of this report for MLTSS and other medical services.

B. RATE DEVELOPMENT STANDARDS

i. Capitation rate structure

The MyCare rate structure for CY 2020 did not change from the 2019 rate structure. Rates continue to vary by region consistent with current geographic definitions. The NFLOC rate cell continues to reflect a composite of the Institutional, Community Waiver 18 – 44, Community Waiver 45 – 64 and Community Waiver 65+ population groups. The NFLOC rate cell will be adjusted by the MEMA on a semi-annual basis. The Community Well population groups includes three separate rate cells: Community Well 18 – 44, Community Well 45 – 64, and Community Well 65+ for a total of four MyCare rate cells.

Community Well

The Community Well category represents eligible dual members who do not meet the NFLOC standard (including the transition rules) as described later in this section. Within the Community Well category, capitation rates vary by contracting region and the following age groups: 18 - 44, 45 - 64 and 65+.

NFLOC

The NFLOC category represents MyCare-eligible members who are enrolled in the MyCare Waiver or covered as a long-term nursing facility (NF) resident (i.e. Institutional population group).

MyCare Waiver enrollees

- An individual who enrolls in the MyCare Waiver will be assigned to the NFLOC rate cell at the beginning of the month following enrollment in the waiver or in the current month if enrollment begins on the first day of the month.

Institutional Population

- An individual must have 100 or more consecutive days billed as NF services based on combined Medicare and Medicaid days to be considered a long-term resident of a NF and included in the Institutional population group.
- Gaps in NF care of 15 days or less per discharge count toward the consecutive day requirement.
- Any days that a member spends in an inpatient hospital setting, once already admitted to a NF, count toward the 100-day requirement.
- Hospice Room and Board days count toward the 100 consecutive day requirement.

Once a Medicaid recipient achieves the one-hundredth NF day (regardless of payer), the member will be assigned to the NFLOC rate cell in the subsequent month and the plan would then be paid the higher rate associated with this population.

NF residents that have been in a NF for 100 or more days immediately preceding that member's enrollment in the MyCare program will be classified into the NFLOC rate cell on the first day of enrollment.

For the NFLOC rate cell, there is a single rating category for each contracting region. The rates are developed using data from the following NFLOC population groups: Institutional, Community Waiver 18 - 44, Community Waiver 45 - 64 and Community Waiver 65+. Current enrollment in MyCare was used as a basis for the projected enrollment distribution by population group for CY 2019. The composite NFLOC rates reflect the anticipated mix of NFLOC members achieved through effective managed care activities.

Transition Rules

Members who had met the criteria for inclusion in the NFLOC rate cell, but later do not, will be transitioned to the Community Well category. The MCOP will continue to receive the NFLOC capitation rate for three full months following the change in categorization. Beginning with the fourth month, the plan will receive the Community Well capitation rate. For members who transition from Community Well to a nursing facility, the member will be assigned to the NFLOC rate cell in the month following the member's one-hundredth day. Members who transition from Community Well to the MyCare waiver will be assigned to the NFLOC rate cell in the month immediately following transition.

C. APPROPRIATE DOCUMENTATION

i. Rate certification and supporting documentation for MLTSS

(a) Capitation rate structure

The blended structure for the NFLOC rate cell, along with the rationale and payment methodology are discussed in a previous section.

(b) Methodology

The structure, rationale, and payment methodology are discussed in a previous section.

(c) Other Payment Structures

The structure, rationale, and payment methodology are discussed in a previous section.

(d) Utilization and unit cost effect

The assumed utilization impact of ongoing transitions from the institution to the community waiver setting on projected trends for waiver services are discussed in a previous section.

(e) Managed care effect

The blended nature of the NFLOC rate cell encourages MCOPs to manage the mix of the population towards lower cost settings. This is the basis for efficiencies in LTSS programs. This transition between settings (e.g. nursing facility to HCBS waiver services) is gradual in nature and is not an immediate transition. Most often, individuals that are in a nursing facility for a long period of time have lost their community supports and it becomes difficult to change the setting away from a nursing facility. Therefore, MCOPs will need to seek individuals that are newer to LTSS benefits and avoid or delay nursing facility placement. Because of this, we assumed gradual increases in HCBS percentages and decreases in nursing facility percentages. Our assumption for CY 2020 is that the percentage of NFLOC individuals in a nursing facility will be reduced by 0.5% by the end of the year. This is a decrease from the 1% reduction assumed in CY 2019 as we have observed this member transition between care settings slow down during the CY 2018 base period and through the first half of 2019, but there remains a continued expectation for reasonable managed care efficiency. This assumes MCOPs will transition these individuals to the community waiver setting.

ii. Non-benefit costs

The non-benefit costs vary by population group and are appropriate for the MLTSS benefits and services.

iii. Experience and assumptions

A previous section details the experience and assumptions employed for the LTSS and non-LTSS services included in the MyCare program.

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 2020 actuarially sound capitation rates for the MyCare Ohio Program (MyCare). 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 MCOPs in the development of the calendar year 2020 capitation rates. Milliman has relied upon ODM and the MCOPs 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 July 12, 2019.

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: 2020 Rate Change Summaries

Ohio Department of Medicaid
MyCare Ohio Opt-Out Program
Capitation Rates Effective January 1, 2020
Rate Change Summary

Region: Statewide

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	270,684	$ 4,077.69	$ 4,099.22	0.5%
Community Well 18-44	58,536	356.83	$ 303.11	(15.1%)
Community Well 45-64	126,648	409.12	$ 365.42	(10.7%)
Community Well 65+	119,004	544.06	$ 435.98	(19.9%)
Total	**574,872**	**$ 2,159.11**	**$ 2,131.78**	**(1.3%)**

Region: Central / Southeast

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	29,544	$ 4,495.10	$ 4,744.90	5.6%
Community Well 18-44	7,716	423.94	336.86	(20.5%)
Community Well 45-64	15,000	532.04	455.96	(14.3%)
Community Well 65+	15,132	762.84	582.25	(23.7%)
Total	**67,392**	**$ 2,308.85**	**$ 2,350.91**	**1.8%**

Region: East Central

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	46,776	$ 3,710.99	$ 3,623.66	(2.4%)
Community Well 18-44	7,872	340.08	277.18	(18.5%)
Community Well 45-64	17,964	422.57	345.67	(18.2%)
Community Well 65+	16,608	580.86	452.22	(22.1%)
Total	**89,220**	**$ 2,168.80**	**$ 2,078.04**	**(4.2%)**

Region: Northeast

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	71,352	$ 4,343.90	$ 4,266.90	(1.8%)
Community Well 18-44	14,148	365.25	308.90	(15.4%)
Community Well 45-64	31,608	414.26	371.28	(10.4%)
Community Well 65+	39,216	483.19	434.30	(10.1%)
Total	**156,324**	**$ 2,220.75**	**$ 2,159.55**	**(2.8%)**

Ohio Department of Medicaid
MyCare Ohio Opt-Out Program
Capitation Rates Effective January 1, 2020
Rate Change Summary

Region: Northeast Central

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	16,080	$ 3,901.20	$ 3,772.36	(3.3%)
Community Well 18-44	5,208	317.05	265.47	(16.3%)
Community Well 45-64	11,100	373.03	321.03	(13.9%)
Community Well 65+	9,756	570.06	378.38	(33.6%)
Total	**42,144**	**$ 1,757.89**	**$ 1,644.29**	**(6.5%)**

Region: Northwest

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	16,404	$ 4,049.17	$ 4,123.12	1.8%
Community Well 18-44	5,352	403.29	328.42	(18.6%)
Community Well 45-64	11,400	407.40	373.29	(8.4%)
Community Well 65+	7,980	419.05	345.83	(17.5%)
Total	**41,136**	**$ 1,861.37**	**$ 1,857.46**	**(0.2%)**

Region: Southwest

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	49,248	$ 4,361.03	$ 4,518.99	3.6%
Community Well 18-44	10,956	326.72	302.42	(7.4%)
Community Well 45-64	22,572	383.29	356.57	(7.0%)
Community Well 65+	18,408	532.80	422.74	(20.7%)
Total	**101,184**	**$ 2,340.40**	**$ 2,388.67**	**2.1%**

Region: West Central

Rate Cell	Member Months	July 2019 Capitation Rate	Calendar Year 2020 Capitation Rate	% Change
NFLOC	41,280	$ 3,476.37	$ 3,503.17	0.8%
Community Well 18-44	7,284	327.11	293.46	(10.3%)
Community Well 45-64	17,004	335.90	330.94	(1.5%)
Community Well 65+	11,904	495.00	361.08	(27.1%)
Total	**77,472**	**$ 2,032.88**	**$ 2,022.33**	**(0.5%)**

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

© 2019 Milliman, Inc. All Rights Reserved. The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Materials may not be reproduced without the express consent of Milliman.

APPENDIX F

MARKETING AND MEMBER COMMUNICATIONS

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

1. The MyCare Ohio logo shall be on all member communications and marketing materials, excluding nominal gifts.

2. **Marketing Activities.** Marketing means any communication from an MCOP to an eligible individual who is not a member of that MCOP that can reasonably be interpreted as intended to influence the individual to select membership in that MCOP, or to not select membership in or to terminate membership from another MCOP. When marketing, the MCOP shall:

    a. Ensure representatives, as well as materials and plans, represent the MCOP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud the eligible individuals or ODM.

    b. Ensure no marketing activity directed specifically toward the Medicaid population begins prior to approval by ODM.

    c. Not engage directly or indirectly with cold-call marketing activities including, but not limited to, door-to-door or telephone contact. Cold-call marketing means any unsolicited personal contact by the MCOP with an eligible individual for the purpose of marketing.

    d. Receive prior approval from any event or location where the MCOP plans to provide information to eligible individuals.

    e. Not offer material or financial gain, including but not limited to, the offering of any other insurance, to an eligible individual as an inducement to select MCOP membership.

    f. Not offer inducements to any county department of job and family services (CDJFS) or Ohio Medicaid Consumer Hotline staff or to others who may influence an individual's decision to select MCOP membership.

    g. Be permitted to offer nominal gifts prior-approved by ODM to an eligible individual as long as these gifts are offered whether or not the individual selects membership in the MCOP.

    h. Be permitted to reference member incentive/appreciation items in marketing presentations and materials; however, such member items shall not be made available to non-members.

    i. Not make marketing presentations, defined as a direct interaction between an MCOP's marketing representative and an eligible individual, in any setting unless requested by the eligible individual.

j. Offer the ODM-approved solicitation brochure to the eligible individual at the time of the marketing presentation and shall provide:

   i. An explanation of the importance of reviewing the information in the ODM-approved solicitation brochure, how the individual can receive additional information about the MCOP prior to making an MCOP membership selection, and the process for contacting ODM to select an MCOP.

   ii. Information that membership in the particular MCOP is voluntary and a decision to select or not select the MCOP will not affect eligibility for Medicaid or other public assistance benefits.

   iii. Information that each member shall choose a PCP and shall access providers and services as directed in the MCOP's member handbook and provider directory. Upon request, the MCOP shall provide eligible individuals with a provider directory.

   iv. Information that all medically necessary Medicaid covered services, as well as any additional services provided by the MCOP, will be available to all members.

k. Identify and resolve any confusion or service issues that may have motivated the member's request for a change in enrollment prior to initiating member-requested Medicare marketing contact with a current or pending member for any corporate-family Medicare Advantage (MA) or Medicare Special Needs Plan (SNP) product. MCOP member services representatives or care managers shall also educate the member about the MCOP's dual benefits membership option. Once the issues are resolved and clarification about MCOP integrated enrollment is made, the member shall be invited to rescind the marketing request.

l. Never offer 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 MCOPs, as all enrollment activities shall be completed by the Hotline.

3. **Marketing Representatives and Training.** An MCOP that utilizes marketing representatives for marketing presentations requested by eligible individuals shall comply with the following:

   a. All marketing representatives shall be employees of the MCOP. A copy of the representative's job description shall be submitted to ODM.

   b. No more than 50% of each marketing representative's total annual compensation, including salary, benefits, and bonuses may be paid on a commission basis. For the purpose of this rule, any performance-based compensation would be considered a form of commission. Upon ODM request, the MCOP shall make available for inspection, the compensation packages of marketing representatives.

   c. Marketing representatives shall be trained and duly licensed by the Ohio Department of Insurance to perform such activities.

d. The MCOP shall develop and submit to ODM for prior approval (at initial development and at the time of revision) a marketing representative training program which shall include:

   i. A training curriculum including:

      1. A full review of the MCOP's solicitation brochure, provider directory, and all other marketing materials including all video, electronic, and print.

      2. An overview of the applicable public assistance benefits designed to familiarize and impart a working knowledge of these programs.

      3. The MCOP's process for providing sign language, oral interpretation, and oral translation services to an eligible individual to whom a marketing presentation is being made, including a review of the MCOP's written marketing materials.

      4. Instruction on acceptable marketing tactics, including a requirement that the marketing representatives may not discriminate on the basis of age, gender, gender identity, sexual orientation, disability, race, color, religion, national origin, military status, genetic information, ancestry, health status, or the need for health services.

      5. An overview of the ramifications to the MCOP and the marketing representatives if ODM rules are violated.

      6. Review of the MCOP's code of conduct or ethics.

   ii. Methods that the MCOP will utilize to determine initial and ongoing competency with the training curriculum.

e. Any MCOP staff person providing MCOP information or making marketing presentations to an eligible individual shall:

   i. Visibly wear an identification tag and offer a business card when speaking to an eligible individual and provide information which ensures the staff person is not mistaken for an Ohio Medicaid Consumer Hotline, federal, state or county employee.

   ii. Inform eligible individuals the following MCOP information or services are available and how to access the information or services:

      1. Sign language, oral interpretation, and oral translation services at no cost to the member.

      2. Written information in the prevalent non-English languages of eligible individuals or members residing in the MCOP's service area.

      3. Written information in alternative formats.

iii. Not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, military status, ancestry, disability, genetic information, health status, or the need for health services.

iv. Not ask eligible individuals questions related to health status or the need for health services.

f. Only ODM approved MCOP marketing representatives may make a marketing presentation upon request by the eligible individual or in any way advise or recommend to an eligible individual that he or she select MCOP membership in a particular MCOP. As provided in ORC Chapter 1751. and Section 3905.01, all non-licensed agents, including providers, are prohibited from advising or recommending to an eligible individual that he or she select MCOP membership in a particular MCOP as this would constitute the unlicensed practice of marketing.

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

4. **Marketing Materials.** Marketing materials are those items produced in any medium, by or on behalf of the MCOP, 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 5160-58-01.

a. Marketing materials shall comply with the following requirements:

i. Be available in a manner and format that may be easily understood.

ii. Written materials developed to promote membership selection in the MCOP shall be available in the prevalent non-English languages of eligible individuals in the service area and in alternative formats in an appropriate manner that takes into consideration the special needs of eligible individuals including but not limited to visually-impaired and LRP eligible individuals.

iii. Oral interpretation and oral translation services shall be available for the review of marketing materials at no cost to eligible individuals.

iv. Be distributed to the MCOP's entire service area.

v. The mailing and distribution of all MCOP marketing materials shall be prior-approved by ODM and may contain no information or text on the outside of the mailing that identifies the addressee as a Medicaid recipient.

vi. Not contain any assertion or statement (whether written or oral) that the MCOP is endorsed by the Centers for Medicare and Medicaid Services (CMS), the federal or state government or similar entity.

b. ODM or its designee may, at the MCOP's request, mail MCOP marketing materials to the eligible individuals. Postage and handling for each mailing will be charged to the requesting MCOP. The MCOP address shall not be used as the return address in mailings to eligible individuals

processed by ODM.

c. **Solicitation Brochure**. The MCOP shall have a solicitation brochure available to eligible individuals which contains, at a minimum:

i. Identification of the Medicaid recipients eligible for the MCOP's coverage.

ii. Information that the MCOP's ID card replaces the member's monthly Medicaid card.

iii. A statement that all medically-necessary Medicaid-covered services will be available to all members, including Healthchek services for those individuals under age 21.

iv. A description of any additional services available to all members.

v. Information that membership selection in a particular MCOP is voluntary, a decision to select MCOP membership or to not select MCOP membership in the MCOP will not affect eligibility for Medicaid or other public assistance benefits, and individuals may change MCOPs under certain circumstances.

vi. Information on how the individual can request or access additional MCOP information or services, including clarification on how this information can be requested or accessed through:

1. Sign language, oral interpretation, and oral translation services at no cost to the eligible individual;

2. Written information in the prevalent non-English languages of eligible individuals or members in the MCOP's service area;

3. Written information in alternative formats.

vii. Clear identification of corporate or parent company identity when a trade name or DBA is used for the Medicaid product.

viii. A statement that the brochure contains only a summary of the relevant information and more details, including a list of providers and any physician incentive plans the MCOP operates will be provided upon request.

ix. Information that the individual shall choose a PCP from the MCOP's provider panel and the PCP will coordinate the member's health care.

x. Information that a member may change PCPs at least monthly.

xi. A statement that all medically necessary health care services shall be obtained in or through the MCOP's providers except emergency care, behavioral health services provided through facilities, and any other services or provider types designated by ODM.

xii. A description of how to access emergency services including emergency services are available within and outside the service area.

xiii. A description of the MCOP's policies regarding access to providers outside the service area.

xiv. Information on member-initiated termination options in accordance with OAC rule 5160-58-02.1.

xv. Information on the procedures an eligible individual shall follow to select membership in an MCOP including any applicable ODM selection requirements.

xvi. If applicable, information on any member co-payments the MCOP has elected to implement in accordance with OAC rule 5160-26-12.

5. **Marketing Plan.** The MCOP shall submit an annual marketing plan to ODM including all planned activities for promoting membership in or increasing awareness of the MCOP. The marketing plan submission shall include an attestation by the MCOP that the plan is accurate and is not intended to mislead, confuse, or defraud the eligible individuals or ODM.

6. **ODM Approval.** The MCOP is responsible for ensuring all new and revised marketing materials (including materials used for marketing presentations) and member materials (including mailing and distribution) are approved by ODM prior to distribution to eligible individuals or members. The MCOP shall include with each marketing submission an attestation that the material is accurate and is not intended to mislead, confuse, or defraud the eligible individuals or ODM. In accordance with 42 CFR 438.104(c), ODM will consult with the Medical Care Advisory Committee in reviewing all MCOP submitted marketing materials.

7. **Alleged Marketing Violations.** The MCOP shall immediately notify ODM in writing of its discovery of an alleged or suspected marketing violation. ODM will forward information pertaining to alleged marketing violations to the Ohio Department of Insurance and the Medicaid Fraud Control Unit as appropriate.

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

9. The MCOP shall assist members with maintenance of Medicaid eligibility by providing timely reminders of annual redetermination dates.

10. **Member Materials.** Member materials are those items developed by or on behalf of the MCOP to fulfill MCOP program requirements or to communicate to all members or a group of members. Member materials include member education, member appreciation, and member incentive program information. Member health education materials produced by a source other than the MCOP which do not include any reference to the MCOP are not considered to be member materials.

    a. Member materials shall be:

i. Available in written format and alternative formats in an appropriate manner that takes into consideration the special needs of the member including, but not limited to, visually-limited and LRP members.

ii. Provided in a manner and format that may be easily understood;

iii. Printed in the prevalent non-English languages of members in the service area upon request; and

iv. Consistent with the practice guidelines specified in paragraph (B) of OAC rule 5160-26-05.1.

b. MCOP member materials shall not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODM.

11. **Issuance of Member Materials.** The MCOP shall provide members with a variety of materials, including at a minimum those specified in OAC rules, this Agreement, and the Three-Way. The following provides clarification regarding the issuance of specific member materials.

a. **New Member Materials.** The MCOP shall provide to each member or assistance group that selects or changes MCOP, or changes Medicaid-only or dual benefit status, an MCOP identification (ID) card, a new member letter, waiver handbook, and a member handbook postcard, if provided in lieu of the full handbook.

i. **ID Cards.** The MCOP shall mail ID cards to each member via a method that will ensure receipt no earlier than 15 calendar days prior to the member's effective date of coverage and no later than one calendar day prior to the member's effective date of coverage.

1. The MCOP will meet the timeliness requirement for mailing ID cards to members who select or change MCOPs, or change Medicaid-only or dual benefit status within the 5 business days prior to the end of the month, if the ID cards are mailed within:

a. 5 business days of the MCOP receiving the ODM produced HIPAA 834C listing the individual as a Medicaid-only member; or

b. 10 business days of the MCOP receiving the ODM-produced HIPAA 834C listing the individual as a dual benefits member.

2. The MCOP ID card shall contain:

a. The MCOP's name as stated in its article of incorporation and any other trade or DBA name used;

b. The name of the member(s) enrolled in the MCOP and each member's medical management information system billing number;

c. The name and telephone numbers of the PCPs assigned to the members;

d. Information on how to obtain the current eligibility status of the members;

e. Pharmacy information;

f. The MCOP's emergency procedures including the toll-free call-in system phone numbers; and

g. The toll-free 24-hour behavioral health crisis and care management telephone numbers as prescribed by ODM.

3. For Medicaid Only members when a contracted primary care provider (PCP) is not identified on the consumer contact record (CCR) and the member does not select a PCP, the ID card PCP field shall read "Refer to Medicare PCP".

ii. **Advance Directives.** Information concerning a member's right to formulate, at the member's option, advance directives including a description of applicable state law shall be provided to the member no later than the effective date of coverage.

iii. **Member Handbook and New Member Letter.** The MCOP shall use the model language specified by ODM and/or CMS for the new member letter and member handbooks.

1. The MCOP shall mail the new member letter, waiver handbook, if applicable, and member handbook postcard that provides how a member can obtain a printed or electronic version of the member handbook, separate from the ID card. The MCOP will meet the timeliness requirement for mailing these materials if they are mailed to members within five business days of the MCOP receiving the ODM produced HIPAA 834C, that lists the individual as a new member.

2. The MCOP New Member Letter shall inform each member of the following:

a. The new member materials issued by the MCOP, what action to take if he or she did not receive those materials, and how to access the MCOP's provider directory;

b. How to access MCOP-provided transportation services;

c. How to change primary care providers;

d. The population groups not required to select MCOP membership and what action to take if a member believes he or she meets this criteria and does not want to be an MCOP member;

e. The need and time frame for a member to contact the MCOP if he or she has a health condition the MCOP should be aware of in order to most appropriately manage or transition the member's care; and

f. The need and how to access information on medications that require prior authorization.

3. The MCOP Member Handbook shall be clearly labeled as such and shall include:

a. The rights of members including all rights found in OAC rule 5160-26-08.3 and any member responsibilities specified by the MCOP. With the exception of any prior authorization (PA) requirements the MCOP describes in the member handbook, the MCOP cannot establish any member responsibility that would preclude the MCOP's coverage of a Medicaid-covered service.

b. Information regarding services excluded from MCOP coverage and the services and benefits available through the MCOP and how to obtain them, including at a minimum:

i. All services and benefits requiring PA or referral by the MCOP or the member's PCP;

ii. Self-referral services, including Title X services, and women's routine and preventative health care services provided by a woman's health specialist as specified in OAC rule 5160-26-03;

iii. FQHC, RHC, and certified nurse practitioner services specified in OAC rule 5160-26-03; and

iv. Any applicable pharmacy utilization management strategies prior-approved by ODM.

c. Information regarding available emergency services, the procedures for accessing emergency services and directives as to the appropriate utilization, including:

i. An explanation of the terms "emergency medical condition," "emergency services," and "post-stabilization services," as defined in OAC rule 5160-26-01;

ii. A statement that PA is not required for emergency services;

iii. An explanation of the availability of the 911 telephone system or its local equivalent;

iv. A statement that members have the right to use any hospital or other appropriate setting for emergency services; and

v. An explanation of the post-stabilization care services requirements specified in OAC rule 5160-26-03.

d. The procedure for members to express their recommendations for change to the MCOP.

e. Identification of the categories of Medicaid recipients eligible for MCOP membership;

f. Information stating that the MCOP's ID card replaces the member's monthly Medicaid card, how often the card is issued, and how to use it;

g. A statement that medically necessary health care services shall be obtained through the providers in the MCOP's provider network with any exceptions such as emergency care;

h. A description of Healthchek services, including who is eligible and how to obtain Healthchek services through the MCOP;

i. Information on additional services available to members including care management;

j. A description of the MCOP's policies regarding access to providers outside the service area for non-emergency services and if applicable, access to providers within or outside the service area for non-emergency after hours services;

k. Information on member initiated termination options in accordance with OAC rule 5160-58-02.1;

l. Information about MCOP-initiated terminations;

m. An explanation of automatic MCOP membership renewal in accordance with OAC rule 5160-58-02;

n. The procedure for members to file an appeal, a grievance, or state hearing request as specified in OAC rule 5160-58-08.4, the MCOP's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the MCOP. Copies of the form(s) to file an appeal or grievance shall also be made available through the

MCOP's member services program;

o. The standard and expedited state hearing resolution time frames as outlined in 42 CFR 431.244.

p. The member handbook issuance date;

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

r. An explanation of subrogation and coordination of benefits;

s. A clear identification of corporate or parent identity when a trade name or DBA is used for the Medicaid product;

t. Information on the procedures for members to access behavioral health services;

u. Information on the MCOP's advance directives policies, including a member's right to formulate advance directives, a description of applicable state law, and a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

v. A statement that the MCOP provides covered services to members through a provider agreement with ODM, and how members can contact ODM;

w. The toll-free call-in system phone numbers;

x. A statement that additional information is available from the MCOP upon request including, at a minimum, the structure and operation of the MCOP and any physician incentive plans the MCOP operates;

y. Process for requesting or accessing additional MCOP information or services including at a minimum:

    i. Oral interpretation or translation services;

    ii. Written information in the prevalent non-English languages in the MCOP's service areas; and

    iii. Written information in alternative formats.

z. If applicable, detailed information on any member co-payments the MCOP imposes in accordance with OAC rule 5160-26-12;

aa. How to access the MCOP's provider directory;

iv. The MCOP shall provide access to provider panel information to members via the MCOP's website and printed provider directories.

1. The MCOP may mail ODM prior-approved provider directory notices to all new members in lieu of mailing printed directories. The notices shall be mailed with the member materials specified in this appendix and, at a minimum, advise members they may call the MCOP to request printed provider directories and access the information on the MCOP's website.

2. An MCOP that does not use an ODM prior-approved provider directory notice shall mail printed provider directories to all new members with the member materials specified in this appendix.

3. When a member requests a printed provider directory, the printed provider directory shall be sent to the member within seven calendar days of the request.

v. **Waiver Handbook**. A waiver handbook must be provided to an individual enrolled in the MyCare Ohio Waiver.

b. **Annual material**. If a member's MCOP membership is automatically renewed as specified in OAC rule 5160-58-02, the MCOP shall issue an ID card prior to the new effective date of coverage. Additional annual member materials include:

i. The member handbook postcard if the member handbook has been revised since the initial MCOP membership date;

ii. Waiver handbooks to members enrolled in the MyCare Ohio Waiver. The MCOP is responsible for ensuring each MyCare Ohio Waiver enrollee receives the Waiver Member Handbook at the time of enrollment, and also at the time of each annual reassessment. The MCOP is responsible for ensuring the Waiver Care Manager or Waiver Service Coordinator has verbally reviewed the content of the handbook, and the MCOP shall maintain documentation signed by the enrollee of receipt of this information.

1. For a member who has chosen waiver services, the MCOP shall have an ODM-developed freedom of choice form signed by the member indicating he or she has chosen waiver services over institutional care. This form shall be signed at the time the member enrolls in the waiver. In addition, it shall be signed annually thereafter at the time of reassessment of waiver eligibility, closest to the member's level of care redetermination.

2. The MCOP will provide an ODM-approved handbook on self-direction detailing processes, to all members directing their own care.

c. The MCOP shall use the model language specified by ODM for the new member letter and as applicable, model language for CMS letters regarding Cancellation of Enrollment and Confirmation of Voluntary Disenrollment Following CMS Daily Transaction Reply Report (DTRR).

12. No information or text that identifies the addressee as a Medicaid recipient may appear on the outside of any MCOP or MCOP subcontractor marketing or member material mailing.

13. **Information Required for MCOP Websites.**

a. **On-line Provider Directory**. The MCOP shall have an internet-based provider directory in the same format as its ODM-approved provider directory, that allows members to electronically search for the MCOP panel providers based on name, provider type, and geographic proximity (as specified in Appendix H and the Three-Way Contract). MCOP provider directories shall include all MCOP-contracted providers (except as specified by ODM) as well as all federally qualified health centers, rural health centers, qualified family planning providers, and free-standing birth centers (FBCs) as defined in OAC 5160-18-01 located in the MCOP's service regions. If the MCOP does not have contracted certified nurse midwives (CNMs) or certified nurse practitioners (CNPs) in a service region, then the MCOP shall specify that CNM and CNP services are available and members can contact the MCOP for information on accessing those services. The provider directory shall be the same for both Medicaid-only and dual eligible members.

b. **On-line Member Website**. The MCOP shall have a secure internet-based website which provides members the ability to submit questions, comments, grievances, and appeals, and receive a response. Members shall be given the option of a response by return email or phone call. The MCOP's responses to questions or comments shall be made within one business day of receipt. The MCOP's responses to grievances and appeals shall adhere to the timeframes specified in OAC rule 5160-58-08.4. The member website shall be regularly updated to include the most current ODM-approved materials, although this website shall not be the only means for notifying members of new and/or revised MCOP information (e.g., change in holiday closures, changes in additional benefits, and revisions to approved member materials). The MCOP shall make a copy of its Authorized Representative request form available to members through its online member portal located on the MCOP's website.

c. The MCOP member website shall also include, at a minimum, the following information which shall be accessible to members and the general public without any log-in restriction:

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

ii. A listing of the counties the MCOP serves unless the MCOP serves the entire state in which case the MCOP may indicate it services the entire state;

iii. The ODM-approved MCOP member handbook, waiver handbook, recent newsletters and announcements;

iv. The MCOP's on-line provider directory as referenced in this appendix;

v. A list of services requiring prior authorization (PA);

vi. The MCOP's preferred drug list (PDL), including an explanation of the list and identification of any preferred drugs that require PA, the MCOP'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 MCOP's policy for coverage of generic versus brand name drugs;

vii. A 30 calendar days advance notice of changes to the list of all services requiring PA, as well as the MCOP's PDL and list of drugs requiring PA. The MCOP shall provide a hard copy of notification of any PA changes upon request;

viii. The toll-free telephone numbers for the 24/7 medical advice, behavioral health crisis, and care management support services call-in systems specified in section 28 of this appendix;

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

x. The toll-free member services, 24/7 call-in systems, and transportation scheduling telephone numbers shall be easily identified on either the MCOP's website home page or a page that is a direct link from a contact button on the home page. ODM may require the MCOP to include additional information on the member website as needed; and

xi. All Healthchek information as specified in Appendix C.

14. The MCOP shall receive prior written approval from ODM before adding any information to its website that would require ODM prior approval in hard copy form (e.g., provider listings, member handbook information). The MCOP may make the website changes available for public use during ODM's review period, however the MCOP shall indicate that the website change is pending ODM review until ODM has either approved or disapproved of the update.

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

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

APPENDIX G

COVERAGE AND SERVICES

1. **Basic Benefit Package.** After consideration of third party liability, including Medicare coverage pursuant to OAC rules 5160-58-01.1 and 5160-26-09.1, the MCOP shall ensure its members have timely access to all medically-necessary medical, drug, emergency and post-stabilization, behavioral health, nursing facility, and home and community-based waiver services covered by Medicaid pursuant to OAC rules 5160-58-03, 5160-58-04, and 42 CFR 438.114 in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid in accordance with 42 CFR 438.210. This coverage shall be with limited exclusions, limitations, and clarifications (see OAC rule 5160-58-03 and specified in this appendix). The MCOP shall also ensure its members have access to any additional services specified in this Agreement. For information on Medicaid-covered services, the MCOP shall refer to the Ohio Department of Medicaid (ODM) website.

   Services covered by the MCOP benefit package include:

   a. Inpatient hospital services;

   b. Outpatient hospital services;

   c. Services provided by rural health clinics (RHCs) and federally qualified health centers (FQHCs);

   d. Physician services whether furnished in the physician's office, the member's home, a hospital, or elsewhere;

   e. Laboratory and x-ray services;

   f. Screening, diagnosis, and treatment services to children under the age of 21 under the Healthchek, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. These services include all mandatory and optional medically necessary services (including treatment) and items listed in 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illness and conditions. Such services and items, if approved through prior authorization, include those services and items listed at 42 U.S.C. 1396d(a), including services provided to members with a primary diagnosis of autism spectrum disorder, in excess of state Medicaid plan limits applicable to adults. An EPSDT screening is an examination and evaluation of the general physical and mental health, growth, development, and nutritional status of an individual under age 21. It includes the components set forth in 42 U.S.C. 1396d(r) and shall be provided by plans to children under the age of twenty-one;

   g. Family planning services and supplies;

   h. Home health and private duty nursing services in accordance with OAC Chapter 5160-12. State plan home health and private duty nursing services shall be accessed prior to using the same or similar waiver funded services;

   i. Podiatry;

j. Chiropractic services;

k. Physical therapy, occupational therapy, developmental therapy, and speech therapy;

l. Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services;

m. Free-standing birth center services in free-standing birth centers as defined in OAC rule 5160-18-01;

n. Prescribed drugs;

o. Ambulance and ambulette services;

p. Dental services;

q. Durable medical equipment and medical supplies, including expedited wheelchair fitting, purchase, maintenance and repair, professional evaluation, home assessment, the services of skilled wheelchair technicians, pick-up and delivery, timely repairs, training, demonstration, and loaner chairs;

r. Vision care services, including eyeglasses;

s. Nursing facility services;

t. Hospice care;

u. Behavioral health services including those provided by Ohio Department of Mental Health and Addiction Services (OhioMHAS)-certified providers, as described in OAC Chapter 5160-27;

v. Immunizations, following the coverage requirements provided by ODM for any newly approved vaccine under the Vaccines for Children (VFC) program;

w. Preventive services covered by Ohio Medicaid in accordance with Section 4106 of the Affordable Care Act and 42 CFR 440.130(c);

x. All U.S. Preventive Services Task Force (USPSTF) grade A and grade B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration, without cost-sharing, as provided in Section 4106 of the Affordable Care Act. Additionally, the MCOP shall cover, without cost-sharing, services specified under Public Health Service Act Section 2713, in alignment with the Alternative Benefit Plan;

y. Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit, as described in OAC rule 5160-1-16. ;

z. Telemedicine;

aa. Services for members with a primary diagnosis of Autism Spectrum Disorder (ASD) including coverage mandated by ORC section 1751.84; and

bb. Home and community-based waiver services as listed in OAC rule 5160-58-04.

2. **Exclusions.** The MCOP is not required to pay for services not covered by the Medicaid program, except as specified in OAC rule 5160-58-03 or this Agreement. Information regarding non-covered services can be found on the ODM website. Services not covered by the Medicaid program include:

   a. Services or supplies not medically necessary;

   b. Treatment of obesity unless medically necessary;

   c. Experimental services and procedures, including drugs and equipment, not in accordance with customary standards of practice;

   d. Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother;

   e. Infertility services;

   f. Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure;

   g. Reversal of voluntary sterilization procedures;

   h. Plastic or cosmetic surgery not medically necessary. (These services could be deemed medically necessary if medical complications or conditions in addition to the physical imperfection are present);

   i. Sexual or marriage counseling;

   j. Biofeedback services;

   k. Services to find cause of death (autopsy) or services related to forensic studies;

   l. Paternity testing;

   m. Services determined by another third-party payer as not medically necessary;

   n. Drugs not covered by the Ohio Medicaid pharmacy program as specified in OAC 5160-9-03;

   o. Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual. Assisted suicide services do not include withholding or withdrawing medical treatment, nutrition or hydration or the provision of a service for the purpose of

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

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

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

3. Clarifications.

a. **Member Cost-Sharing.** As specified in Appendix A, Section 3.3 of the Three-Way, the MCOP may elect to implement co-payments for Medicaid-covered drugs, but shall not charge cost sharing to members above levels established under the Medicare Part D Low Income Subsidy. Pursuant to Appendix C, Section 3.3(C) of the Three-Way, members who reside in a nursing facility or are enrolled in the MyCare 1915(c) waiver may be required to contribute to the cost of care the amount of patient liability established by the County Department of Job and Family Services.

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

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

c. Boards of Alcohol, Drug Addiction and Mental Health Services. Pursuant to ORC Chapter 340, boards of alcohol, drug addiction and mental health services serve as the community addiction and mental health planning agencies for the county or counties under their jurisdiction. These boards may advocate on behalf of Medicaid recipients enrolled in managed care whom have been identified as needing behavioral health services and are required to:

i. Evaluate the need for facility services, addiction services, mental health services, and recovery supports; and

ii. Establish a unified system of treatment for mentally ill persons and persons with addictions.

d. **Institutions for Mental Disease (IMDs) for Mental Health Stays.** In accordance with 42 CFR 438.6(e), the MCOP may provide mental health services to members ages 21 through 64 for up to 15 days per calendar month while receiving inpatient treatment in an IMD as defined in Section 1905(i) of the Social Security Act. The MCOP is not prohibited from contracting with an IMD to provide mental health services to members' ages 21 through 64, but Medicaid will not compensate the MCOP for the provision of such services beyond 15 days per calendar month either through direct payment or considering any associated costs in Medicaid rate setting. MCOP payments to the IMD are established in the plan's contractual agreement with the provider. The MCOP is required to report quarterly on IMD stays exceeding 15 days per calendar month per ODM's specifications.

e. **Substance Use Disorder (SUD) Treatment.** The MCOP will continue to work with ODM in development of the 1115 SUD demonstration waiver to provide services to individuals with an SUD diagnosis. The MCOP must utilize the American Society of Addiction Medicine (ASAM) level of care criteria and cannot add additional criteria when reviewing level of care for SUD treatment provided in a community behavioral health center. The MCOP must use the adolescent ASAM level of care criteria for individuals under the age of 21 years. Additional work will include increasing care coordination efforts and monitoring IMD network adequacy.

f. **Urine Drug Screening.** The MCOP shall abide by the urine drug screening guidelines for individuals with substance use disorder as specified by ODM.

g. **Acupuncture.** Ohio Medicaid acupuncture coverage is limited to the pain management of migraine headaches and lower back pain.

h. **Gender Transition.** Under 45 CFR 92.207(b)(4), 81 Federal Register (FR) 31471-72, the MCOP is prohibited from having or implementing a categorical coverage exclusion or limitation for all health services related to gender transition. However, 45 CFR92.207(d) clarifies this does not prevent the MCOP from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in individual cases.

i. **Hospice Services**. In accordance with 1905(o)(3)(C) and 1902(a)(32) of the Act, and 42 CFR 447.10, the MCOP shall pay room and board payments to the hospice provider instead of the nursing facility if the member resides in a nursing facility and is receiving hospice services.

j. **Inpatient Hospital Services.** When billing inpatient hospital services, the MCOP shall follow the three calendar day roll-in requirements as described in OAC rule 5160-2-02.

4. **Information Sharing with Non-Panel Providers.** To assist members in accessing medically-necessary Medicaid-covered services, the MCOP is required to share specific information with certain non-panel providers. The information is to assist non-panel providers to recognize MCOP membership, access information needed to provide services, and, if applicable, successfully submit claims to the MCOP.

a. **ODM-Designated Providers.** The MCOP shall share specific information with FQHCs/RHCs, qualified family planning providers (QFPPs), hospitals, and if applicable, certified nurse midwives (CNMs), certified nurse practitioners (CNPs), and free-standing birth centers (FBCs) as defined in OAC rule 5160-18-01 within the MCOP's service area and in bordering regions if appropriate based on member utilization information. The information shall be shared within the first month after the MCOP has been awarded a Medicaid provider agreement for a specific region and annually thereafter. At a minimum the information shall include:

   i. The information's purpose;

   ii. Claims submission information including the MCOP's Medicaid provider number for each region (this information is only required to be provided to non-panel FQHCs/RHCs, QFPPs, CNMs, CNPs, and hospitals);

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

   iv. A picture of the MCOP's member ID card (front and back);

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

   vi. A listing of the MCOP's pharmacies, laboratories, and radiology providers.

b. **MCOP-Authorized Providers.** The MCOP authorizing the delivery of services from a non-panel provider shall ensure it has a mutually agreed upon compensation amount for the authorized service and shall notify the provider of the applicable provisions of OAC rules 5160-58-01.1 and 5160-26-05. This notice is provided when the MCOP authorizes a non-panel provider to furnish services on a one-time or infrequent basis to the MCOP member and shall include required ODM-model language and information.

c. Upon request, the MCOP shall provide information to ODM to document the non-contracting providers identified by the MCOP and the information provided to each provider. An MCOP that requires referrals to specialists shall ensure information on referral approvals and denials is made available to ODM upon request.

5. **Mental Health Parity and Addiction Equity Act (MHPAEA) Requirements**. The MCOP shall comply with MHPAEA requirements outlined in 42 CFR Part 438 Subpart K, with regard to services provided to managed care members. The following requirements apply to the provision of all covered benefits to all populations included under the terms of this Agreement. The MCOP shall:

   a. Demonstrate to ODM that all covered services are being delivered in compliance with the MHPAEA regulation.

b. Participate in ODM requested meetings, respond to ODM information requests, work with ODM to resolve compliance risks, and notify ODM of any changes to benefits or limitations that might impact compliance.

c. Conduct an analysis each calendar year to determine compliance with MHPAEA and provide results of the analysis to ODM. If no changes have been made to the MCOP's covered services, the MCOP may attest to compliance with MHPAEA. The analysis or attestation will be due to ODM during the month of December, no later than December 31st.

d. Work with ODM to ensure all members are provided access to a set of benefits that meets the MHPAEA requirements regardless of which behavioral health services are provided by the MCOP.

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

APPENDIX H

PROVIDER PANEL SPECIFICATIONS

1. **Federal Access Standards.** The MyCare Ohio Plan (MCOP) shall provide or arrange for the delivery of all medically necessary, Medicaid-covered health services in a timely manner, and ensure compliance with federally defined provider panel access standards as required by 42 CFR 438.206.

    a. In establishing and maintaining its provider panel, the MCOP shall consider the following:

        i. The anticipated Medicaid membership.

        ii. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the MCOP.

        iii. The number and types (in terms of training, experience, and specialization) of panel providers required to deliver the contracted Medicaid services.

        iv. The geographic location of panel providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.

        v. The MCOP shall adequately and timely cover services from an out-of-network provider if the MCOP's contracted provider panel is unable to provide the services covered under the MCOP's provider agreement. The MCOP shall cover the out-of-network services for as long as the MCOP network is unable to provide the services. The MCOP shall coordinate with the out-of-network provider with respect to payment and ensure the provider agrees with the applicable requirements.

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

    c. In order to comply with 42 CFR 438.206 and 438.207, and demonstrate adequate provider panel capacity and services, the MCOP shall submit documentation as specified to the Ohio Department of Medicaid (ODM), in a format specified by ODM, demonstrating the MCOP offers an appropriate range of preventive, primary care, specialty, behavioral health, family planning, and waiver 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 shall be submitted to ODM no less frequently than at the time the MCOP enters into a contract with ODM; at any time there is a significant change (as defined by ODM) in the MCOP's operations that would affect adequate capacity and services (including

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

d. When a waiver enrollee expresses a preference for an independent (non-agency) provider for an eligible service identified on the member's person-centered service plan, the MCOP shall seek out an available independent provider. The MCOP shall offer the independent provider a contract for provision of the services to the member when the provider is willing, acceptable to the member, and appropriate to the member's care, and approved by ODM or the Ohio Department of Aging (ODA) with an active Medicaid provider agreement to render services in accordance with OAC Chapters 173-39 and 5160-45 as appropriate.

2. **General Provisions.** The MCOP shall remain in compliance with the following requirements for the duration of this Agreement.

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

b. If the MCOP offers transportation to its members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit as specified in Appendix C.

c. In developing the provider panel requirements, ODM considered the population size and the potential availability of the designated provider types. ODM 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 or within a set number of miles from a zip code.

d. The MCOP shall ensure that providers submitted to the Managed Care Provider Network (MCPN), or listed in MCOP published directories, are available to both dual benefits and Medicaid only members of the MCOP.

e. ODM will recalculate the minimum provider panel specifications if ODM determines significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population. The MCPN is the tool that will be used for ODM to determine if the MCOP meets all the panel requirements identified within Appendix H; therefore the plans shall enter all network providers as specified within the file specs.

f. On a monthly basis, ODM or its designee will provide each MCOP with an electronic file containing the MCOP's provider panel as reflected in the ODM MCPN database, or other designated system.

3. **Provider Subcontracting.** Unless otherwise specified in this appendix or OAC rules 5160-58-01.1 and 5160-26-05, the MCOP is required to enter into fully-executed subcontracts with its providers. These subcontracts shall include a baseline contractual agreement, as well as the appropriate ODM-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable OAC rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCOP's name.

    a. As required by 42 CFR 438.608, all network providers must be enrolled with ODM.

        i. Except in single case agreements, prior to contracting with a provider and/or listing the provider as a network provider, the MCOP shall either:

            1. Validate the provider is:

                a. Active on the Provider Master File;

                b. Enrolled for the service and specialty, as applicable; and

                c. Eligible to render the specific waiver service, when applicable, using the Provider Master File or ODA-certified provider file; or

            2. Direct the provider to the ODM public portal to submit application for screening and enrollment.

        ii. In accordance with 42 CFR 438.602, an MCOP may execute a temporary 120 calendar day network provider agreement pending the outcome of the ODM screening, enrollment, and revalidation process. The MCOP must terminate the provider immediately upon notification from ODM that the network provider cannot be enrolled, or the expiration of one 120 calendar day period without enrollment of the provider, and notify affected members. In this instance, no advance contract termination notice to the provider is required. If a provider applicant does not identify with a provider type that is available on the web application, they must complete a form specified by ODM and the MCOP shall submit the form to ODM for screening and enrollment. The application can be found at: http://www.medicaid.ohio.gov/Provider/EnrollmentandSupport/ProviderEnrollment.

        iii. The MCOP may only pay a provider who is enrolled unless the provider is rendering service with a temporary 120 calendar day agreement, a single-case agreement, or for emergency services in accordance with 42 CFR 438.114.

    b. The MCOP may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. Only those providers who meet the applicable criteria specified in this document, and as determined by ODM, will be counted toward meeting minimum panel requirements. The MCOP shall credential and re-credential providers in accordance with OAC rules 5160-58-01.1 and 5160-26-05. The MCOP shall ensure the provider has met all applicable credentialing criteria before the

provider can be listed as a panel provider. At the direction of ODM, the MCOP shall submit documentation verifying all necessary contract documents have been appropriately completed.

c. The MCPN is a centralized database system that maintains information on the status of MCOP-submitted providers. At a minimum, the MCOP shall submit providers associated with the provider types specified in this appendix, which includes Sections 2.6 and 2.7 of the Three-Way with the exception of independent providers. The MCOP shall notify ODM of the addition and deletion of its contracting providers as specified in OAC rules 5160-58-01.1 and 5160-26-05, and shall notify ODM within one business day, in instances where the MCOP has identified it is not in compliance with the provider panel requirements specified in this appendix. For provider deletions, the MCOP shall complete and submit an electronic record terminating the provider from the MCPN or other designated system.

4. **Provider Panel Requirements.** Failure to contract with, and properly report to the MCPN, all MCOP contracted providers will result in sanctions as outlined in Appendix N. ODM will grant an 'exception to the issuance of sanction' only when an action taken by ODM has adversely impacted a plan's ability to meet the provider panel network or when a provider is not available in the required zip code, county, and/or region.

   a. All MCOPs shall provide all medically-necessary Medicaid-covered services to their members. The MCOP shall ensure all network providers follow community standards in the scheduling of routine appointments (i.e., the amount of time members shall wait from the time of their request to the first available time when the visit can occur).

   b. In addition to requirements set forth in the Three-Way, the MCOP shall comply with all provider network requirements set forth in this appendix except as explicitly noted herein.

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

      ii. **Vision Care Providers**. The MCOP shall contract with at least the minimum number of ophthalmologists and optometrists for each specified county and region, all of whom shall maintain a full-time practice at a site(s) located in the specified county and region to count toward minimum panel requirements listed in Table 3. All ODM-approved vision providers shall regularly perform routine eye exams. The MCOP will be expected to contract with an adequate number of ophthalmologists as part of its 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 MCOP's contracting ophthalmologists/optometrists, the MCOP shall separately contract with an adequate number of optical dispensers located in the region.

iii. **Dental Care Providers**. The MCOP shall contract with at least the minimum number of dentists listed in Table 3.

iv. **Waiver Providers**. The MCOP shall ensure MyCare Ohio HCBS waiver providers listed in Table 1 meet the requirements set forth in OAC Chapters 173-39 and 5160-45, as appropriate, and have an active Medicaid provider agreement with ODM. The MCOP shall validate that waiver providers hold applicable approval from ODM or certification from the Ohio Department of Aging for each waiver service to be rendered.

v. **Independent Providers.** The MCOP shall have a written policy setting forth a regular payment cycle for clean claims submitted by independent providers. The MCOP shall adhere to the policy and any communications from the MCOP to a provider shall be consistent with the policy.

vi. **Nursing Facilities**. The MCOP shall contract with at least the minimum number of facilities identified in Table 2. If a contracted nursing facility experiences a CHOP, the plan shall not require the new nursing facility to request a new authorization for members who had a previous authorization that is still current.

vii. **Behavioral Healthcare Providers**. The MCOP shall evaluate each region's network capacity of behavioral health (BH) services (both Medicare and Medicaid). The MCOP shall perform an assessment of no less than its contracted Medicare providers in each region and county regarding providers' willingness and preparedness to become Medicaid providers of the behavioral health services. The MCOP shall also assess whether each region and county's behavioral healthcare providers are currently certified for Medicare or are prepared and willing to pursue certification for Medicare services. The MCOP shall report the results to ODM upon request.

1. **Community Behavioral Health Center (CBHC) Laboratories**. When the MCOP is contracted with a CBHC that is an appropriately credentialed laboratory and meets Medicaid provider-eligibility requirements as a laboratory, the MCOP is directed to accept the CBHC laboratory into their panel to allow for continuity of care. (CBHCs include both substance use disorder treatment providers and community mental health centers.)

2. **Substance Use Disorder (SUD) Treatment Providers**. The MCOP shall contract with at least the minimum number of Ohio Department of Mental Health and Addiction Services (OhioMHAS)-certified SUD treatment providers identified in Table 4

3. **Medication Assisted Treatment (MAT) Prescribers**. The MCOP shall contract with at least the minimum number of MAT prescribers identified in Table 6, as well as all willing Opioid Treatment Programs (OTPs) licensed by OhioMHAS and certified by Substance Abuse and Mental Health Services Administration (SAMHSA). Contracted OTPs count towards the MCOP's required number of contracted MAT prescribers. Noncompliance with MAT prescriber contracting requirements will be enforced beginning July 1, 2020. The MCOP shall report

any additional providers prescribing MAT not previously identified by ODM as specified by ODM.

4. **Community Mental Health Centers (CMHCs)**. The MCOP shall contract with at least the minimum number of OhioMHAS-certified CMHCs identified in Table 4. In addition, the MCOP shall ensure adequate provider panel capacity to provide its members with reasonable and timely access to the following services within the region, if available; Community Psychiatric Supportive Treatment, Crisis Intervention, individual counseling, group counseling, injections (long-acting antipsychotic medications), mental health assessment, partial hospitalization, pharmacological management, psychiatric diagnostic interview, and psychological testing.

5. **Other Behavioral Health Treatment Providers.** The MCOP shall contract with at least the minimum number behavioral health providers identified in Table 5. This includes independent marriage and family therapists, licensed independent chemical dependency counselors, licensed independent social workers, psychologists, etc., who do provide services outside of the SUD treatment providers and CMHCs listed above.

viii. **Qualified Laboratories.** When an out-of-network qualified laboratory provides toxicology test results to the referring health care provider within two business days of receipt of the test specimen, the MCOP shall pay that laboratory at least sixty percent of the Medicaid laboratory services fee schedule. For urine drug screens, the ODM urine drug screen guidelines shall be followed as specified in Appendix G of this Agreement. For the purposes of this requirement, a qualified laboratory is a laboratory that is enrolled with Medicaid as an independent laboratory, and that meets all of the following conditions:

1. Is accredited by the College of American Pathologists;

2. Is approved by the New York Clinical Laboratory Evaluation Program; and

3. Indicates to the MCOP that is it providing services and billing as a qualified laboratory under this requirement.

ix. **Federally Qualified Health Centers (FQHCs).** Pursuant to the Three-Way Contract, MCOP payments to FQHCs should be no less than the sum of the following:

1. The level and amount of payment that the MCOP would make for such services provided by a non-FQHC provider; and

2. The difference between 80% of the Medicare fee-for-service rate for the FQHC and the Medicaid prospective payment system (PPS) amount for the FQHC, where the Medicaid PPs amount exceeds 80% of the Medicare rate.

5. **Provider Directories.** The MCOP's provider directory shall include all MCOP-contracted providers as well as certain non-contracted providers as specified by ODM with the exception of independent providers and those providers operating under single case agreements. At the time of ODM's review, the information listed in the MCOP's provider directory for all MCOP contracted providers shall exactly match the data currently on file in the ODM MCPN, or other designated process.

    a. The MCOP's provider directory shall utilize a format specified by ODM. The directory may be region-specific, include multiple regions, or, with prior-approval from ODM, be proximity-based to the member ; however, the providers within the directory may be divided by county and provider type. The directory shall also specify the following when available and applicable:

        i. Provider's name as well as any group affiliation;

        ii. Provider's street addresses;

        iii. Provider's telephone numbers;

        iv. Provider's website URL;

        v. Provider's specialty;

        vi. Indication of the provider's office/facility accessibility and accommodations (e.g. offices, exam room(s), and equipment);

        vii. Indication of whether the provider is accepting new members;

        viii. Indication of the provider's linguistic capabilities, including the specific language(s) offered, including ASL, and whether they are offered by the provider or a skilled medical interpreter at the provider's office;

        ix. Provider's cultural competence training status; and

        x. How members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals including but not limited to, visually-limited, LEP, and LRP eligible individuals.

        xi. For the CY 2021 provider directory, the MCOP must describe in detail any sole-sourced or selectively contracted network providers (e.g. durable medical equipment). The description must clearly identify:

            1. The services, including supplies or equipment, that must be obtained from the provider;

            2. How to obtain the services;

            3. How to contact the provider; and

4. How to obtain services to meet an urgent need (i.e. additional supplies needed post-surgery or for vacation).

b. **Printed Provider Directory**. The MCOP's printed provider directory shall be prior-approved by ODM. Once approved, in accordance with 42 CFR 438.10, this directory may be updated with provider additions or deletions by the MCOP without ODM prior-approval; however, a copy of the revised directory (or inserts) shall be submitted to ODM prior to distribution to members. Any revisions to the printed provider directory format must be approved by ODM before distribution.

c. **Internet Provider Directory**. The MCOP is required to have an internet-based provider directory available in a format prior approved by ODM. This internet directory shall allow members to electronically search for MCOP panel providers based on name, provider type, provider specialty, and geographic proximity. If the MCOP has one internet-based directory for multiple populations, each provider shall include a description of which population they serve. Any revisions to the internet provider directory format must be approved by ODM before implementation. If the MCOP receives updated provider information, this directory shall be updated in accordance with the timeframes listed in 42 CFR 438.10

Table 1. Waiver Provider Panel.

MyCare Region		Community Transition	Emergency Response	Home Maintenance/Chore	Home Medical Equipment & Supplies	Home Modifications	Homemaker	Community Integration	Meals Home Delivered	Nutritional Counseling	Out of Home Respite		Social Work Counseling	Waiver Transportation	Waiver Nursing Agency	Personal Care-Agency
Central		2	19	18	19	8	56	2	9	1	1		2	2	42	124
East Central		2	10	11	10	15	24	2	9	2	1		2	6	22	97
Northeast		2	16	16	6	6	34	2	13	2	1		2	8	28	119
Northeast Central		2	5	2	4	2	10	2	5	3	1		2	2	10	43
Northwest		2	3	4	3	2	4	2	10	2	1		2	2	20	45
Southwest		2	10	15	6	7	16	2	19	4	1		2	4	21	75
West Central		2	4	8	7	8	6	2	8	6	1		2	5	28	75

Table 2. Nursing Facility Provider Panel.

MyCare Region	County	NFs
Central	Delaware	3
Central	Franklin	16
Central	Madison	1
Central	Pickaway	2
Central	Union	1
East Central	Portage	2
East Central	Stark	11
East Central	Summit	14
East Central	Wayne	5
Northeast	Cuyahoga	31
Northeast	Geauga	2
Northeast	Lake	4
Northeast	Lorain	4
Northeast	Medina	4
Northeast Central	Columbiana	5
Northeast Central	Mahoning	7
Northeast Central	Trumbull	7
Northwest	Fulton	2
Northwest	Lucas	12
Northwest	Ottawa	2
Northwest	Wood	4
Southwest	Butler	7
Southwest	Clermont	4
Southwest	Clinton	1
Southwest	Hamilton	23
Southwest	Warren	6
West Central	Clark	4
West Central	Greene	3
West Central	Montgomery	12
	Grand Total	**199**

Table 3. Vision/Dental Provider Panel.

Northeast	Vision	Dental
Cuyahoga	32	85
Geauga	0	1
Lake	2	7
Lorain	3	11
Medina	1	4
Total	38	110

East Central	Vision	Dental
Portage	0	3
Stark	7	17
Summit	11	23
Wayne	0	3
Total	18	46

Northeast Central	Vision	Dental
Columbia	0	2
Mahoning	5	11
Trumbull	4	8
Total	9	21

Central	Vision	Dental
Delaware	3	3
Franklin	20	60
Madison	0	1
Pickaway	1	1
Union	1	1
Total	25	66

Northwest	Vision	Dental
Fulton	0	0
Lucas	9	26
Ottawa	0	1
Wood	2	2
Total	11	31

West Central	Vision	Dental
Clark	3	6
Greene	3	3
Montgomery	13	23
Total	19	32

Southwest	Vision	Dental
Butler	4	13
Clermont	1	5
Clinton	1	1
Hamilton	14	34
Warren	2	3
Total	22	56

Table 4. Community Behavioral Health Center (CBHC) Provider Panel.

MyCare Region	OhioMHAS-certified Community Mental Health Centers	OhioMHAS-certified Substance Use Disorder (SUD) Treatment Providers
Central	18	8
East Central	19	8
Northeast	50	8
Northeast Central	10	6
Northwest	10	6
Southwest	28	8
West Central	19	6

Table 5. Other Behavioral Health Provider Panel (not provider types 84 or 95).

Region	Required Number
Northwest	43
Central	30
West Central	39
Southwest	53
Northeast	99
East Central	54
Northeast Central	33

Table 6. Medication Assisted Treatment Provider Panel. Noncompliance with MAT prescriber contracting requirements will be enforced beginning July 1, 2020.

County	MAT	County	MAT	County	MAT	County	MAT
Butler	8	Fulton	0	Madison	1	Stark	6
Clark	2	Geauga	1	Mahoning	12	Summit	14
Clermont	4	Greene	5	Medina	1	Trumbull	4
Clinton	0	Hamilton	30	Montgomery	18	Union	0
Columbiana	3	Lake	4	Ottawa	0	Warren	4
Cuyahoga	34	Lorain	2	Pickaway	2	Wayne	1
Delaware	1	Lucas	14	Portage	2	Wood	2
Franklin	43						

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

APPENDIX I

PROGRAM INTEGRITY

The MCOP shall comply with all applicable state and federal program integrity requirements, including, but not limited to, those specified in 42 CFR Part 455, 42 CFR Part 1002 and 42 CFR Part 438 Subpart H.

1. **Fraud, Waste, and Abuse Program.** In addition to the specific requirements of OAC rules 5160-58-01.1 and 5160-26-06, and in accordance with Ohio Department of Medicaid's (ODM's) 1915(c) and 1915(b) CMS-approved waiver, the MCOP shall have a program that includes administrative and management arrangements or procedures to detect and prevent fraud, waste, and abuse. The MCOP's compliance program shall address the following:

    a. **Compliance Program.** In accordance with 42 CFR 438.608, the MCOP shall implement and maintain a compliance program that includes all the following:

        i. A compliance plan that includes designated staff responsible for administering the plan and clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and an explanation of how the MCOP will determine the effectiveness of the compliance plan.

        ii. Written policies, procedures, and standards of conduct that demonstrate compliance with all applicable requirements and standards under this Agreement, as well as all federal and state requirements related to program integrity.

        iii. A designated Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with the program integrity requirements. The Compliance Officer shall report to the Chief Executive Officer and the Board of Directors.

        iv. A Regulatory Compliance Committee, consisting of members of the Board of Directors and senior management, which is responsible for oversight of the MCOP's compliance program.

        v. A system for training and education for the Compliance Officer, the MCOP's senior management, and the MCOP's employees regarding the MCOP's compliance program and program integrity related requirements.

        vi. Effective lines of communication between the Compliance officer and the MCOP's employees.

        vii. Enforcement of standards through well-publicized disciplinary guidelines.

        viii. A system of dedicated staff with established and implemented procedures for routine internal monitoring and auditing of service patterns of providers and subcontractors, compliance risks, prompt response to compliance issues, investigations of potential compliance problems identified in the course of self-evaluation and audits, correction of

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

ix. Education of providers and delegated entities about fraud, waste, and abuse.

x. Establishment and/or modification of internal MCOP controls to ensure the proper submission and payment of claims.

xi. Prompt reporting of all instances of suspected provider fraud, waste, and abuse to ODM and suspected member fraud, waste, and abuse to ODM's Bureau of Program Integrity.

xii. A fraud, waste, and abuse plan that includes a risk-based assessment, designated staff responsible for administering the plan, clear goals, milestones or objectives, key dates for achieving identified outcomes, and an explanation of how the MCOP will determine effectiveness of the plan. The fraud, waste, and abuse plan shall include, but is not limited to, the following:

1. A risk-based assessment shall include the MCOP's evaluation of its fraud, abuse, and program integrity processes.

2. A risk-based assessment shall include the MCOP's evaluation of risk for fraud and abuse in the provision of services by providers to Medicaid beneficiaries.

3. An outline of activities proposed by the MCOP for the next reporting year which is established from the risk-based assessment results.

4. An outline of activities proposed by the MCOP for the next reporting year regarding provider education of federal and state laws and regulations related to Medicaid program integrity and on identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments.

5. A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:

a. A list of automated pre-payment claims edits;

b. A list of automated post payment claims edits;

c. A list of desk audits on post payment review of claims;

d. A list of reports of provider profiling and credentialing used to aid program and payment reviews; and/or

e. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services.

6. Work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk to ensure services are rendered and billed correctly.

b. **Employee Education about False Claims Recovery.** The MCOP shall comply with Section 6032 of the Deficit Reduction Act of 2005, regarding employee education and false claims recovery, specifically the MCOP shall:

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

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

2. The MCOP's policies and procedures for detecting and preventing fraud, waste, and abuse; and

3. The laws governing the rights of employees to be protected as whistleblowers. In addition, the MCOP shall communicate the following whistleblower fraud and/or abuse reporting contacts to all employees, providers and subcontractors:

a. ODM 1-614-466-0722 or at: http://medicaid.ohio.gov/RESOURCES/HelpfulLinks/ReportingSuspectedMedicaidFraud.aspx;

b. Medicaid Fraud Control Unit (MFCU) 1-800-642-2873 or at: http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud; and

c. The Ohio Auditor of State (AOS) 1-866-FRAUD-OH or by email at: fraudohio@ohioauditor.gov.

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

iii. In accordance with 42 CFR 438.608, establish written policies for any MCOP 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 MCOP's policies and procedures for detecting and preventing fraud, waste, and abuse. The MCOP shall make such information readily available to their subcontractors; and

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

c. **Monitoring for Fraud, Waste, and Abuse**. The MCOP shall specifically address the MCOP's strategies for prevention, detection, investigation, and reporting in at least the following areas:

i. **Credible Allegations of Fraud**. The MCOP shall monitor activities on an ongoing basis to prevent and detect activities involving suspected fraud, embezzlement, and theft (e.g., by staff, providers, contractors) and report findings promptly to ODM as specified in this appendix.

ii. **Underutilization of Services**. In order to ensure all Medicaid-covered services are provided, as required, monitoring of the following areas shall occur:

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

2. The MCOP shall annually review their appeals process for providers following the MCOP's denial of a prior authorization request for a determination as to whether the appeals process unreasonably limits a member's access to Medicaid-covered services;

3. The MCOP shall monitor, on an ongoing basis, service denials, and utilization in order to identify member services which may be underutilized; and

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

iii. **Claims submission and billing**. On an ongoing basis, the MCOP shall identify and correct claims submission and billing activities which are potentially fraudulent including, at a minimum, double-billing and improper coding, such as upcoding and unbundling, to the satisfaction of ODM.

2. **Special Investigative Unit (SIU).**

a. At a minimum, the MCOP shall utilize a full-time, single lead investigator based in Ohio to identify risk and guard against fraud, waste, and abuse, monitor aberrant providers, and refer potential fraud, waste, and abuse to ODM by:

i. Conducting fraud, waste, and abuse investigations;

ii. Preparing investigatory reports;

iii. Submitting and monitoring deconflictions; and

iv. Implementing the Compliance Plan and Fraud, Waste, and Abuse Plan.

b. The lead investigator shall be dedicated solely to ODM program integrity work and meet the following qualifications:

i. A minimum of two years in healthcare field working in fraud, waste, and abuse investigations and audits;

ii. A Bachelor's degree, or an Associate's degree with an additional two years working in health care fraud, waste, and abuse investigations and audits, or ODM will accept experience and certifications commensurate with the educational requirements. ODM will evaluate the experience and certifications in lieu of the educational requirements; and

iii. Ability to understand and analyze health care claims and coding.

c. The lead investigator shall participate in SIU coordination with ODM Program Integrity in areas such as fraud referrals, audits and investigations, deconflictions, overpayments, provider terminations, among other activities, as well as attend any required meetings as prescribed by ODM.

d. **Education and Training**. The MCOP shall ensure that the SIU lead participates in all MCPIG meetings, the Biweekly Home Health Care Fraud meeting and holds quarterly SIU lead meetings to discuss fraud referrals and other program integrity issues.

3. **Reporting MCOP Monitoring of Fraud, Waste, and Abuse Activities.** Pursuant to OAC rules 5160-58-01.1 and 5160-26-06, the MCOP shall report annually to ODM a summary of the MCOP's monitoring of credible allegations of fraud, waste, and abuse, underutilization of member services, limits to Medicaid-covered services, audits and reviews performed, referrals to ODM for fraud and abuse, overpayments identified and recovered, provider terminations for cause, and suspicious claims submission and billing. The MCOP's report shall also identify any proposed changes to the MCOP's compliance plan for the coming year.

a. **Reporting Suspected Fraud, Waste, and Abuse**. The MCOP is required to promptly report all instances of suspected provider fraud, waste, and abuse to ODM and member fraud, waste, and abuse to ODM's Bureau of Program Integrity (BPI), copying the appropriate county department of job and family services (CDJFS). If the MCOP fails to properly report a case of suspected fraud, waste or abuse before the suspected fraud, waste or abuse is identified by the State of Ohio, its designees, the United States or private parties acting on behalf of the United States, any portion of the fraud, waste or abuse recovered by the State of Ohio or designees shall be retained by the State of Ohio or its designees.

i. **Credible Allegation of Provider Fraud**. The MCOP shall promptly refer suspected cases of provider fraud in the ODM specified form to ODM for investigation and determination of whether a credible allegation of fraud exists. If a credible allegation of fraud exists, at the direction of ODM, the MCOP shall immediately suspend all payments to the provider and shall immediately suspend the provider in accordance with ORC section 5164.36. At

the request of ODM staff, ODM's designee, the Ohio Attorney General's Office (AGO) or federal agencies, the MCOP shall produce copies of all MCOP fraud, waste, and abuse investigatory files and data (including, but not limited to records of recipient and provider interviews) within 30 calendar days unless otherwise agreed upon by ODM.

ii. **Credible Allegation of Member Fraud**. All suspected member fraud, waste, and abuse shall be immediately reported to Bureau of Program Integrity (BPI) at Program_Integrity_County_Referral@medicaid.ohio.gov and a copy reported to the appropriate CDJFS.

b. **Referrals and Attestations**. The MCOP shall submit fraud, waste, and abuse referrals to ODM using the ODM Referral form. Each fraud referral submitted to ODM will be distributed to all MCOPs.

c. The ODM Clearinghouse shall review all fraud, waste, and abuse referrals from MCOPs to determine whether there is a credible allegation of fraud or if the allegation evidences abuse or waste. ODM will submit all fraud referrals to the AGO MFCU and return the abuse and waste referrals to the MCOP.

d. The MCOP shall respond to all fraud referrals by submitting the ODM Attestation form to ODM within 90 calendar days. A failure to file an attestation timely, completely, and accurately may result in the MCOP waiving its right to participate in any Attorney General Office (AGO) MFCU recoveries.

e. **Monitoring for Prohibited Affiliations**. The MCOP's policies and procedures for ensuring, pursuant to 42 CFR 438.610, the MCOP will not knowingly have a relationship or prohibited affiliation with individuals debarred by Federal Agencies, as specified in Article XII of this Agreement. Pursuant to 42 CFR 438.608, it is the duty of the MCOP to disclose to ODM any prohibited affiliations under 42 CFR 438.610.

f. **Provider Indictment**. If an indictment is issued, charging a non-institutional Medicaid provider or its owner, officer, authorized agent, associate, manager, or employee with committing an offence specified in ORC Section 5164.37(E), and ODM suspends the provider agreement held by the non-institutional Medicaid provider, at the direction of ODM, the MCOP shall immediately suspend the provider and terminate Medicaid payments to the provider for Medicaid services rendered in accordance with ORC Section 5164.37(D).

g. The MCOP shall disclose to ODM any information regarding change in ownership and control within 35 calendar days in accordance with 42 CFR 455.104, OAC rule 5160-1-17.3, and subcontractors as governed by 42 CFR 438.230.

h. In accordance with 42 CFR 455.105, the MCOP shall submit within 35 calendar days of the date requested by ODM or the U.S. Department of Health and Human Services full and complete information about:

i. The ownership of any subcontractor with whom the MCOP 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 MCOP and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

i. The MCOP shall disclose the following information on persons convicted of crimes in accordance with 42 CFR 455.106 who have:

i. Ownership or control interest in the provider, or is an agent or managing employee of the provider; and

ii. Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

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

j. The MCOP shall notify ODM when the MCOP denies credentialing to a provider for program integrity reasons.

k. The MCOP shall notify ODM when there is a change in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including when a provider panel application is denied or a provider panel agreement is terminated for program integrity reasons. The MCOP shall provide the reason for the denial or the termination.

l. The MCOP shall provide to ODM a quarterly report of all open program integrity related audits and investigations related to fraud, waste, and abuse activities for identifying and collecting overpayments, utilization review, and provider compliance. The report shall include, but is not limited to, audits and investigations performed, overpayments identified, overpayments recovered, and other program integrity actions taken; such as, corrective action plans, provider education, financial sanctions, and sanctions by a provider, during the previous contracting period and for each ongoing quarter.

m. **Coordination with Law Enforcement**. The MCOP shall stand down upon submission of either a fraud, waste, or abuse referral or a submission of a request for deconfliction.

i. **Referrals.**

1. Upon MCOP submission of a fraud, waste, or abuse referral to ODM, the MCOP shall stand down.

2. The stand down time period will last for the shortest of the following events:

    a. ODM determines there is no credible allegation of fraud contained in the referral;

    b. AGO MFCU closes their investigation for lack of prosecutorial merit; or

    c. An initial period of one year, starting when the referral is received by ODM. This period may be extended once for an additional time period of six months upon the Program Integrity Director's discretion.

ii. **Deconflictions.**

1. Prior to initiating an audit, investigation, review, recoupment or withhold, or involuntarily terminating a provider, the MCOP must request deconfliction and receive permission from ODM to proceed.

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

    a. If the AGO MFCU has an open case and the MCOP requested deconfliction and received leave to proceed since there wasn't a conflict with an active law enforcement investigation, and

    b. The date of the de-confliction request occurred prior to the date that the AGO MFCU agency opened their case on the same provider, and

    c. The MCOP submits a referral regarding the same provider after completion of its previously approved audit, investigation or review.

2. ODM, upon request of the AGO MFCU, may request that the MCOP stand down after submitting a deconfliction request for fraud, waste or abuse. The stand down time-period will last an initial period of six months after the deconfliction response is sent by ODM.

    a. The Program Integrity Director may extend the stand down an additional six months upon the request of the AGO MFCU and a showing that the extension is warranted.

    b. This provision does not apply to federal cases, joint task force cases or other cases which are not under the AGO MFCU's control.

3. The MCOP may not act to recoup improperly paid funds or withhold funds potentially due to a provider when the issues, services or claims upon which the recoupment or withhold is based on the following:

a. The improperly paid funds were recovered from the provider by ODM, the State of Ohio, the federal government or their designees, as part of a criminal prosecution where the MCOP had no right of participation, or

b. The improperly paid funds are currently being investigated by the State of Ohio, are the subject of pending federal or state litigation or investigation, or are being audited by ODM, the Ohio Auditor of State (AOS), CMS, OIG or their agents.

iii. Absent any restrictions on recovery, the MCOP may otherwise recover from a provider any amount collected from the MCOP by ODM, the Ohio Auditor of State, the federal government, any other regulatory agency, or their designees, relating to an improper payment to such provider by the MCOP which resulted from an audit, review or investigation of the provider. The MCOP shall retain recovery rights to any amount paid to ODM when a provider self-reports an overpayment arising from a payment made by the MCOP to the provider.

iv. The MCOP shall notify ODM when it proposes to recoup or withhold improperly paid funds already paid or potentially due to a provider and obtain ODM approval to recoup or withhold, prior to taking action.

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

n. An MCOP that is not a qualified health maintenance organization shall report to ODM a description of certain transactions with parties of interest as outlined in Section 1903(m)(4)(A) of SSA [42 U.S.C. 1396b(m)(4)(A)].

o. **Treatment of Recoveries made by the MCOP from Overpayments to Providers.** Pursuant to 42 CFR 438.608, the MCOP shall:

i. Immediately notify ODM BPI if the MCOP acts to recoup improperly paid funds (including overpayments due to fraud, waste, and abuse) in violation of this appendix. ODM BPI will issue written instructions, including any applicable timeframes, in response to the notification of improper recovery and the MCOP shall comply with those instructions; and

ii. Require any network provider to report to the MCOP when it has received an overpayment, to return the overpayment to the MCOP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCOP in writing of the reason for the overpayment.

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

4. **Data Certification.** Pursuant to 42 CFR 438.604 and 42 CFR 438.606, the MCOP is required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to ODM which may affect MCOP payment.

    a. The MCOP shall submit the appropriate ODM-developed certification concurrently with the submission of the following data or documents:

        i. Encounter Data, Care Management Data, and HEDIS IDSS Data/FAR as specified in Appendix L; and

        ii. Prompt Pay Reports and Cost Reports as specified in Appendix J;

    b. The above MCOP data submissions shall be certified by one of the following:

        i. The MCOP's Chief Executive Officer;

        ii. The MCOP's Chief Financial Officer; or

        iii. An individual who has delegated authority to sign for, and who reports directly to, the MCOP's Chief Executive Officer or Chief Financial Officer. When the authorization is delegated to another MCOP employee, the CEO or CFO remains responsible.

    c. The MCOP shall provide certification as to the accuracy, completeness, and truthfulness of additional submissions.

5. **Explanation of Benefits (EOB) Mailings.** Pursuant to 42 CFR 455.20, the MCOP shall have a method for verifying with enrollees whether services billed by providers were received; therefore, the MCOP is required to conduct a mailing of EOBs to a 95% confidence level (plus or minus 5% margin of error) random sample of the MCOP's enrollees once a year. As an option, the MCOP may meet this requirement by using a strategy targeting services or areas of concern as long as they number of mailed EOBs is no less than the number generated by the random sample described above. Any MCOP opting to use a targeted mailing shall submit the proposed strategy in writing to ODM and receive written prior approval from ODM. The EOB mailing shall only include those members that have received health care services within the last six months, comply with all state and federal regulations regarding release of personal health information, outline the recent medical services identified as having been provided to the enrollee and request the enrollee report any discrepancies to the MCOP. The MCOP shall inform its Contract Administrator of the date of the EOB mailing and provide results of the mailing 60 to 90 calendar days after the mailing (i.e., number mailed, number of enrollees reporting discrepancies).

6. **Breaches of Protected Health Information.** The MCOP shall submit an annual report to ODM regarding the number of breaches of protected health information (PHI) and specify how many breaches were reported to HHS as required by 45 CFR 164.408(b) and (c).

7. **Waiver Integrity Reporting Requirements**. The MCOP shall perform unit of service /claims validation for waiver services claims in accordance with Ohio's approved 1915(c) waiver, and shall respond promptly to requests for claims verification in support of Provider Certification and Structural Compliance

processes administered by ODM, ODA or their designee. In accordance with ODM's 1915(c) CMS-approved waiver, the MCOP shall report the following information to ODM:

a. In accordance with ODM's 1915(c) CMS-approved waiver, the MCOP shall report semi-annually (January 31 and July 31) or as requested by ODM the number and percent of waiver services claims that have been verified through a review of provider documentation to have been paid in accordance with individuals' person-centered service plans. The MCOP shall review a representative sample stratified by waiver service type, with a confidence interval of 95% with a margin of error of +/- 5%.

b. The MCOP shall report semi-annually (January 31 and July 31) or as requested by ODM the number and percent of claims identified in a., above, for which the MCOP recovered payment. The report shall include verifications that cover the entire period back to the MCOP's MyCare Ohio start-up date.

c. The MCOP shall report the number of providers and members affected in regards to sub-paragraphs a. and b. above. This information is also due on January 31 and July 31.

d. The MCOP shall submit to ODM on an annual basis (July 31) a copy of its independently audited annual financial reports. These annual financial reports shall be audited in accordance with Generally Accepted Auditing Standards by an independent certified public accountant.

8. **Cooperation with State and Federal Authorities.** The MCOP shall provide all data, documentation, information, and other records requested by ODM, the Ohio Attorney General, the Auditor of State, law enforcement, etc. in the manner and format requested; unless an exception is granted by ODM's Director of Program Integrity, the MCOP shall provide the data within thirty calendar days. The MCOP shall cooperate fully with State and Federal Authorities and:

a. The MCOP shall cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal including providing, upon request, information, access to records, and access to interview MCOP subcontractors, employees, and consultants in any manner related to the investigation, and witnesses for trial and other legal or administrative proceedings. The MCOP shall provide the information requested, even if the information is housed with the MCOP's subcontractor or vendor.

b. The MCOP, subcontractors and the MCOP's providers, shall, upon request, make available to ODM BPI, ODM OMC and AGO MFCU/OIG any and all administrative, financial and medical records relating to the delivery of items or services for which ODM monies are expended. Such records will be made available at no cost to the requesting entity.

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

APPENDIX J

FINANCIAL PERFORMANCE

1. Pursuant to Section 2.13, Financial Requirements, of the Three-Way Contract, the MyCare Ohio Plan (MCOP) shall adhere to the financial measures, standards, and reporting requirements contained therein.

2. The MCOP shall adhere to the prompt pay standards set forth in Section 5.1.9. of the Three-Way Contract.

3. Annual and quarterly cost reports shall be revised in accordance with the actuaries' observation log or as otherwise instructed by ODM.

APPENDIX K

QUALITY CARE

This appendix establishes program requirements and expectations related to the MyCare Ohio Plan's (MCOP's) responsibilities for developing and implementing a care delivery model, which includes the establishment of a primary care provider for individuals; health promotion and wellness activities; a care management program; and utilization management programs. The MCOP shall also develop Quality Assessment and Performance Improvement programs and participate in external quality review activities. These program requirements are applicable to dual benefits (opt in) members and Medicaid only (opt out) members and support the priorities and goals set forth in the Ohio Medicaid Quality Strategy.

1. **Care Delivery Model.**

    a. **Primary Care.** In accordance with Section 2.5.1 of the Three-Way, the MCOP is required to ensure each Medicaid only member has a primary care provider who will serve as an ongoing source of primary and preventive care and will perform care coordination activities appropriate to the member's needs.

    b. **Health Promotion and Wellness Activities.** In accordance with Section 2.5.2 of the Three-Way, the MCOP shall develop and offer a range of health and wellness programs and informational material that target specific health needs and risk behaviors identified for the MCOP's membership.

    c. **Direct Access to Specialists.** In accordance with Section 2.6.1.16 of the Three-Way, the MCOP shall implement a provision for members, specifically those with special health care needs, to directly access a specialist (e.g., for an approved number of visits or a standing referral) as appropriate for the member's condition and health care needs. The MCOP shall inform members of their right to directly access a specialist.

    d. **Transitions of Care.** The MCOP shall 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 MCOP shall at a minimum:

        i. Identify members who require assistance transitioning between care settings;

        ii. Develop a method for evaluating risk of readmission in order to determine the intensity and urgency of follow up required for the member after the date of discharge;

        iii. Designate MCOP staff who will regularly communicate with the discharging facility and inform the facility of the designated MCOP contacts;

        iv. Ensure timely notification and receipt of admission dates, discharge dates, and clinical information is communicated between internal MCOP departments and between care settings, as appropriate;

v. Participate in discharge planning activities with the facility including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCOP;

vi. Obtain a copy of the discharge/transition plan;

vii. Arrange for services specified in the discharge/transition plan; and

viii. Conduct timely follow up with the member and member's providers to ensure post discharge services have been provided.

ix. When the MCOP is contacted by an inpatient facility for the MCOP's member, who is not identified in 1.f.i and 1.f.ii, with a request for assistance with discharge planning, the MCOP shall initiate and implement steps 1.f.iii – viii, as applicable, to ensure adequate discharge planning occurs for the member.

x. The MCOP shall ensure the transition/discharge plan and post-discharge services are integrated into the member's care plan. Upon request, the MCOP may be required to submit the transition of care strategy as prescribed by ODM for approval.

e. **Assessments**. Pursuant to Section 2.5.3.2.1. of the Three-Way, the MCOP must have a clear description for conducting or arranging for an assessment that is appropriate for the member's unique circumstances and needs (e.g. medical, behavioral, LTSS, and social needs).

i. The MCOP shall use the ODM-standardized health risk assessment tool or incorporate the standardized health risk assessment questions into the MCOP's current Assessment no later than July 1, 2019.

ii. The MCOP is not required to conduct a new initial comprehensive assessment or annual reassessment if an assessment or reassessment was previously conducted by the current or prior MCOP and one of the following conditions apply:

1. A member remains enrolled with the MCOP; or

2. A member was previously enrolled with the current MCOP in the prior 90 calendar days; or

3. A member had an assessment completed with a prior MCOP and the assessment was transferred from the disenrolling MCOP to the enrolling MCOP per Appendix C.

iii. Updates to the initial assessment shall comply with Section 2.5.3.2.1.8 of the Three-Way agreement.

f. **Care Management Program Requirements.** Pursuant to Section 2.5.3 of the Three-Way, the MCOP shall provide care management services to all members, including dual benefits and Medicaid only. In addition, the MCOP shall also adhere to the following requirements:

   i. For Medicaid only members, the MCOP shall coordinate with any Medicare Advantage Plan that is the primary payer of Medicare services, if applicable, in an effort to reduce gaps or duplication of services.

   ii. The MCOP shall also adhere to all operational standards articulated in the approved Ohio Home and Community-Based Services 1915(c) waiver for MyCare Ohio.

   iii. In accordance with federal regulations, the MCOP must obtain a signature from any waiver service provider acknowledging and affirming agreement to provide the service as authorized on the person-centered service plan per ODM's specifications by December 31, 2018.

   iv. The MCOP shall work with ODM to establish parameters for specific ODM staff to gain access to the MCOP's care management system to reduce administrative burden on the MCOP and ODM, and to improve the efficiency of ongoing incident management and other health, safety, and welfare reviews or investigations of reportable incidents in accordance with OAC rule 5160-44-05. The effective date for this requirement is to be established by ODM at a later date.

g. **Member Safeguards.** The MCOP is required to develop and implement safeguards, systems, and processes to detect, prevent, and mitigate harm and/or risk factors that could impact an individual's health, welfare, and safety. When the MCOP identifies or becomes aware of risk factors, it shall put in place services and supports to mitigate and address the identified issues as expeditiously as the situation warrants.

   i. When a member enrolled in waiver services poses, or continues to pose, a risk to his or her health, safety, and welfare, the MCOP shall develop and implement a health and safety action plan between the MCOP, the member and/or the legal guardian, as applicable. For a member who is not enrolled in waiver services, a health and safety action plan may be used as a tool to mitigate harm and/or risk factors. The health and safety action plan shall identify the risks and set forth interventions recommended by the MCOP to remedy risks to the individual's health, safety, and welfare. The MCOP's process for development and implementation of a health and safety action plan shall be in accordance with ODM's specifications, as described in ODM's "Health and Safety Action Plan Guidance", as a mechanism to facilitate the MCOP's ability to ensure an individual's health, welfare, and safety. The MCOP shall document, in the clinical record, the member's consent or refusal to sign the health and safety action plan, and/or lack of adherence to the agreed upon actions or interventions. The MCOP may submit a request for disenrollment from the 1915(c) waiver, for ODM consideration, when it is believed the health, welfare, and safety of the member cannot be ensured on the waiver program.

ii. ODM or its designee will conduct administrative reviews, in-home checks, and/or other oversight activities to ensure an individual's health, welfare, and safety. The penalties for noncompliance that places a member at risk for a negative health outcome or jeopardizes the health, safety, and welfare of the member are located in Appendix N.

iii. Once the MCOP is notified by ODM of a current or planned loss of provider who delivers ongoing services, including, but not limited to, home health, nursing facilities, etc. the MCOP must immediately identify which individuals are authorized to receive services and ensure that health and safety needs are met (e.g., securing informal support, etc.). The MCOP shall support the individual with selecting a new provider and ensure documentation is reflective of the individual's choice of MCOP-contracted service providers. For a planned loss of a provider, this support should be initiated as expeditiously as possible prior to the provider's end of service date. For a current loss of a provider, support should be initiated no later than two business days after the notification, but as expeditiously as possible.

h. **Conflict Free Care Management.** The MCOP shall abide by the conflict free case management standards set forth in 42 CFR 441.301(c)(1)(vi) and 42 CFR 441.730(b).

i. **Care Management Staffing.** The MCOP shall employ a methodology for assigning consistent and appropriate caseloads for care managers that ensures health, welfare, and safety for members. The MCOP shall incorporate the following factors into its caseload assignment methodology:

i. Population;

ii. Acuity status mix;

iii. Care manager qualifications, years of experience, and responsibilities;

iv. Provision of support staff; location of care manager (community, MCOP office, provider office);

v. Geographic proximity of care manager to members (if community based); and

vi. Access to and capabilities of technology/IT systems.

The MCOP shall ensure there is a method to periodically evaluate caseload assignments, including identification of circumstances that automatically trigger a review or adjustment of caseload sizes. The MCOP shall submit a description of the methodology to ODM as specified and when requested.

j. **Care Management Performance Reviews.** ODM will evaluate the MCOP's care management performance via reviews conducted by ODM, or its designee, in accordance with the MyCare Care Management Performance Review Scoring Methodology.

i. **Measure**: Overall percentage of cases reviewed that received a met rating on the care management performance focus elements.

ii. **Measurement Periods:** TBD

iii. **Minimum Performance Standard:** TBD

k. **Measures, Measurement Periods and Compliance Determination.** ODM reserves the right to revise the measures and measurement periods established in this appendix (and their corresponding 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 MCOP's performance level for that contract period. In the event the MCOP's performance cannot be evaluated for a care management program evaluation measure and measurement period established in this appendix, ODM in its sole discretion will deem the MCOP to have met or to have not the standard(s) for that particular measure and measurement period depending on the circumstances involved.

l. **Data Submission:** The MCOP shall submit four electronic files as follows:

i. **Population Stream.** The MCOP shall submit to ODM a file that contains a population stream for all specified members. The assigned population stream shall align with ODM's population streams: women of reproductive age, behavioral health, chronic condition, and healthy adults. Requirements for this file submission are specified in MyCare Ohio Population Stream Data Submission Specifications.

ii. **Risk Stratification Level.** The MCOP shall submit a file to ODM that contains a risk stratification 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 the MyCare Ohio Risk Stratification Data Submission Specifications.

iii. **Care Management Status.** The MCOP shall submit a file to ODM that contains a care management status for all specified members. The three care management status indicators are outreach and coordination, engaged, and inactive. Requirements for this file submission are specified in the MyCare Ohio Care Management Status Submission specifications.

iv. **Health Risk Assessment.** The MCOP shall submit a file to ODM that contains health risk assessment results for all specified members. Requirements for this file submission are specified in MyCare Ohio Health Risk Assessment Submission Specifications.

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

m. **HCBS Waiver Operational Reporting Requirements.** The MCOP shall report the following to ODM on the 15th of July, October, January, and April of each calendar year:

i. Total number of individuals who have an health and safety action plan by the following categories: drug/alcohol issues, unsafe smoking, noncompliance with healthcare, other.

ii. Total number of individuals with behavior support plans by category: mechanical restraints, chemical restraints, physical, seclusion, and restrictive interventions.

iii. Total number of behavior support plans by category as indicated above by authorizing entity: physician, psychologist, county board of developmental disabilities, and other behavioral health professional.

iv. Total number of individuals with behavior support plans for which the MCOP activated the behavioral support plan with an indication of the used restraint or seclusion.

v. Total number of individuals with behavior support plans for which the MCOP activated the behavioral support plan with an indication of the restrictive intervention used.

vi. In the event the MCOP activates the Emergency Response Plan (ERP) pursuant to Section 2.5.3.3.5.4.6 of the Three-Way, the MCOP shall document the outcomes of the ERP and submit to ODM when requested.

n. **Waiver Service Coordination Assignment.** Pursuant to the Three-Way, the MCOP is required to contract with AAAs and may contract with other entities with experience working with people with disabilities as the primary waiver service coordination option for individuals age 60 and older.

i. The MCOP may assume the responsibility of waiver service coordination entity for any individual regardless of age, if the individual selects or requests a change in the waiver service coordination entity, or if the MCOP, CMS or ODM identity a performance issue that affects an individual's health, welfare, and safety.

ii. The MCOP shall complete the "Monthly Waiver Service Coordination Log" provided by ODM. The monthly log will reflect the number of waiver service coordination assignments for individuals age 60 and older to the MCOP and AAA. The MCOP will make these logs available to ODM upon request.

iii. The MCOP shall share with any AAA that performs waiver service coordination for the MCOP's waiver members the following data elements: care plans, most recent comprehensive assessment and due dates, risk stratification and approved contact schedule, claims including inpatient hospitalizations, emergency departments and waiver services, and risk agreements, as applicable.

o. **Specialized Recovery Services (SRS) Program.** Members who may be eligible to receive Specialized Recovery Services (i.e., recovery management, peer recovery support and individualized placement and support – supported employment), will be assigned a recovery manager who will perform assessments, person-centered planning, and coordination of SRS once determined eligible. Recovery managers will be employed by an Independent Entity. As such, the MCOP is not permitted to perform recovery management services and shall contract

with at least one Independent Entity in the MyCare Ohio service area.

i. The MCOP is responsible for the payment of SRS. The MCOP shall allow members to maintain current service levels at the time of enrollment for at least 180 calendar days after the initial enrollment effective date with the MCOP. After a beneficiary's transition period concludes, the MCOP may prior authorize SRS in accordance with 42 CFR 438.210.

ii. The MCOP will include the recovery manager as part of the member's MyCare Ohio care management team. The SRS person-centered care plan will be integrated into the member's comprehensive care plan. The MCOP's care manager will adhere to ODM's incident management rule specified in OAC 5160-44-05. If an incident is reported to the MyCare care manager for a member receiving SRS, the care manager shall inform the recovery manager. Prevention plans will be jointly developed by the MCOP care manager and the recovery manager.

iii. The MCOP will refer a member who is potentially eligible for SRS to its contracted Recovery Management Agency to initiate the SRS eligibility determination process.

iv. The MCOP must adhere to all operational requirements in the 1915(i) state plan and Ohio Administrative Code (OAC) Chapter 5160-43.

p. **HOME Choice**. HOME Choice is a program designed to assist eligible individuals in moving from institutional settings to community settings. This program will work in tandem with other Medicaid services and community supports, including home and community-based services waiver programs. The MCOP shall adhere to the following:

i. Upon request from HOME Choice staff or their designated entity, the MCOP shall submit a level of care assessment request to the local Area Agency on Aging (AAA).

ii. The MCOP shall authorize community transition services for waiver consumers as appropriate and needed, in accordance with OAC 5160-44-26.

iii. The MCOP shall reimburse authorized community transition services purchases upon invoicing from the Community Transition Services provider.

2. **Quality Improvement (QI) Program.** For the purposes of this Agreement, ODM defines "quality improvement" as a deliberate and defined, science-informed approach that is responsive to member needs and incorporates reliable methods for improving population health. Consistent with this definition, MCOP shall make continuous and ongoing efforts to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes and other indicators of quality in services or processes that achieve equity and improve population health.

a. **Quality Assessment & Performance Improvement (QAPI).** In accordance with 42 CFR 438.330, the MCOP shall establish & implement an ongoing comprehensive QAPI program for the services it furnishes to its enrollees. Updates to the MCOP's QI program shall be submitted to ODM

annually within the QAPI template and shall include the following elements:

i. **QI Program Structure.** The MCOP's quality improvement efforts shall be integrated throughout the organization so that staff at all levels of the organization are (1) fully equipped and have a commitment to improving health outcomes, (2) the results of successful and unsuccessful QI efforts are openly and transparently communicated across the organization and externally in order to foster a culture of innovation in which lessons are quickly learned from failures and successes are sustained and spread, and (3) staff across all levels of the organization are empowered to seek out the root cause of problems and collaboratively test improvement strategies.

ii. **Administrative Oversight.** The MCOP shall establish appropriate administrative oversight arrangements and accountability for the QAPI program. This includes: assignment of a senior QI leadership team responsible for the QI program (e.g., Quality Improvement Director, Medical Director) with a specific focus on the use of improvement projects to optimize health outcomes and reduce disparities; provision for ongoing transparent communication and coordination between the QI leadership team, the CEO and relevant functional areas of the organization; assurance that the Medical Director is involved in all clinically-related projects, and a commitment to providing staff at all levels across the organization with the appropriate education, experience, training, and authority to test and implement improvements that promote population health.

b. **Senior QI Leadership Team.** The MCOP's senior-level QI leadership team provides direction and routine oversight of improvement initiatives. The senior-leadership team is responsible for ensuring that all improvement activities are evaluated on an ongoing basis and that results are used to inform future activities.

The lead for this team shall report directly to the organization's CEO. The team shall manage the organization's QI portfolio and shall be responsible for promoting a culture of QI throughout the organization with improved health outcomes and reductions in health disparities for the Medicaid population as the primary goals. The MCOP shall indicate commitment to improved outcomes and encourage improvement at all levels of the organization through activities that may include the following: clearly linking the MCOP's quality improvement strategy to the organization's and ODM's mission and vision, integrating the voices of members and providers into quality improvement activities (e.g., GEMBA walks, active involvement on QI teams) to determine barriers and intervention strategies, developing the capacity of MCOP staff at all levels of the organization to apply quality improvement tools and principles, dedicating resources and tools to quality initiatives, consistently and frequently using data and analytics strategically to identify improvement opportunities, and track improvement initiative success, transparently sharing quality improvement opportunities and the results of quality improvement initiatives throughout the organization and with ODM.

The MCOP senior level QI leadership team structure should include:

i. Position role and responsibility on the QI leadership team;

ii. Quality improvement training and experience;

iii. The role of each team member in the quality improvement process;

iv. Framework for frequently and transparently sharing information and data throughout the organization to inform improvement activities (e.g. dashboards; newsletters; staff meetings);

v. Dedicated analytic and project management support;

vi. Methods for identifying and assigning needed quality improvement resources;

vii. Methods for building and sustaining quality improvement culture and capacity throughout the organization;

The MCOP shall have established an ODM-approved, senior leadership QI structure that is responsible for ensuring continual improvement of the quality of care and services and championing improvement efforts through such high-impact leadership activities as described in *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

c. **QI Initiative Staffing.** The MCOP shall develop an organization-wide QI culture with dedicated staff devoted to fulfilling a set of clearly defined QI functions and responsibilities that are proportionate to, and adequate for, the planned number and types of QI initiatives. This staffing shall ensure the effectiveness of initiatives on a small scale through quality improvement science-based methods prior to plan-wide implementation, as well as allowing for long-term maintence and spread of effective efforts..

i. **Quality Improvement Teams.** Quality improvement teams shall be composed of MCOP staff dedicated to the Ohio Medicaid line of business that represent the following areas of expertise:

1. Continuous quality improvement,

2. Analytics,

3. Subject matter expertise in clinical and/or nonclinical improvement topic(s) being addressed through improvement efforts,

4. Health equity,

5. Member- and provider-perspectives; and

6. MCOP policies and processes related to the topic.

Team members shall be empowered to test and promote improved MCOP operations, as illustrated by at least one member of the team having decision-making authority for

testing and evaluating changes to plan processes as part of quality improvement activities.

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

ii. **Required QI Responsibilities.**

1. Use of Plan-Do-Study-Act (PDSA) cycles, along with frequent and ongoing data analysis to quickly determine the need for, choice of, and effectiveness of interventions.

2. Use of data to identify improvement opportunities, as well as longitudinal data monitoring and analysis using methods such as statistical process control to differentiate common and special cause variation in order to identify successes and additional opportunities for improvement.

3. Frequent communication with MCOP staff, improvement project team members, the senior leadership team regarding improvement data, lessons learned, opportunities, and progress.

4. Full preparation for and active participation in ODM-sponsored QI meetings and trainings.

5. Inter-and intra-organization collaboration to further ODM's quality goals.

6. Analyzing data to identify disparities in services and/or care and tailoring interventions to specific populations when needed in order to reduce disparities.

7. Active incorporation of member and provider perspectives into improvement activities.

d. **QI Capacity Building.** The MCOP shall build internal quality improvement capacity at all levels of the organization through investment in staff training and hands-on application of ODM-approved quality improvement science tools, methods, and principles in daily work and strategic initiatives.

As a foundation to build upon, MCOP Medical Directors, Quality Improvement Directors, analytic support staff, and at least one MCOP staff person assigned to each improvement team shall complete training, from and ODM approved entity, which includes the active the application of rapid cycle quality improvement tools and methods. The MCOP's QI capacity building efforts shall be clearly illustrated in the annual QAPI submission.

This QI training does not substitute for the certification required in Section 2.2 of the Three-Way.

e. **QI Training Content.** Content shall include, but not be limited to:

   i. The Model for Improvement developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI);

   ii. Edward W. Deming's System of Profound Knowledge;

   iii. Listening to and incorporating the Voice of the Customer (VOC);

   iv. Process mapping/flow charting;

   v. SMART Aim development and the use of key driver diagrams for building testable hypotheses;

   vi. Methods for barrier identification and intervention selection (e.g., root cause analyses, Pareto charts, failure mode and effects analysis, the 5 whys technique, etc.);

   vii. Selection and use of process, outcome, and balancing measures;

   viii. Testing change through the use of PDSA cycles;

   ix. The use of statistical process control, such as the Shewart control chart; and

   x. Tools for spread and sustainability planning.

f. **QI Training Completion.** Training curricula for staff outlined in this appendix shall be submitted to ODM for approval prior to enrollment. Evidence of training completion shall be submitted within 1 month of completion to ODM's Quality Improvement mailbox (ODMQIProjects@medicaid.ohio.gov).

g. **Applying QI Training Concepts**. During and subsequent to quality improvement training, MCOP staff shall actively be involved as team members in at least one quality improvement project in order to continue to build the quality improvement capacity of the MCOP. Active involvement in quality improvement projects involves the applying of quality improvement tools, methods and concepts to a clinical or nonclinical problem, including: analyzing data to determine opportunities for improvement, root cause determination, barrier assessment, intervention design and testing using PDSA cycles, and longitudinal measurement, and assessment of intervention impact on outcome measures using statistical process control methods. Improvement projects shall include the perspective of those whose outcomes are being improved (i.e., members)

h. **QI Training Exemptions**. MCOP staff may be exempted from the training requirement if one of the following is completed within the two years prior to this contract's effective date: 1) an

accredited/certified education course in quality improvement science or 2) satisfactory completion of NCQA, CPHQ or ASQ CQIA certification. Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, as well as Quality Improvement Directors who are hired after July 1, 2016, shall complete the course work within six (6) months of their start date unless they have evidence of course completion within the two years prior to their effective start date, in which case they are exempt.

i. **ODM funded QI training efforts.** MCOP staff at all levels of the organization shall be required to participate in all ODM-funded QI training, as illustrated by being prepared for class and ODM monthly QI meetings, active engagement in class activities and QI meetings, meeting with team and sponsor prior to class and QI meetings, and applying learned concepts to current MCOP improvement projects

j. **MCP Quality Improvement Strategy.** The MCOP shall submit a clearly delineated, outcomes-driven strategy for improvement as part of its annual QAPI submission. The strategy shall measure, analyze, and track performance indicators that reflect the ODM Quality Strategy population health focus, including: population streams (e.g., women's health, chronic conditions, and behavioral health), value based purchasing strategies (e.g., comprehensive primary care, episode-based payments), and health equity focus. The MCOP's quality improvement strategy shall, at minimum describe:

   i. The MCOP leadership team, including leadership positions and how each role supports and champions the MCOP's quality improvement strategy and related initiatives and projects;

   ii. How the MCOP strategy aligns with the ODM Quality Strategy, including how the MCOP will collaborate with other MCOPs on ODM directed population health efforts;

   iii. The MCOP's quality improvement initiatives, including:

      1. How the initiative relates to other MCOP initiatives and the current MCOP and ODM quality strategies;

      2. Criteria considered when choosing and prioritizing the MCOP's improvement projects and initiatives by population stream;

      3. The process for identifying the root causes of prioritized improvement initiatives;

      4. The theory of change for each improvement project (i.e., cause and effect diagrams, key driver diagrams);

      5. The process for incorporating the voice of the customer (e.g., member, provider) into continual efforts to identify areas for improvement, design and prioritize interventions, and improve services and population health;

      6. The roles and responsibilities of staff assigned to the project and resources

allocation to support the improvement effort;

7. Baseline, measures, and measure frequency), target goals and the timeline for their achievement;

8. How newly identified areas for improvement from data analysis and customer input, as well as from the previous year's evaluation are reflected in the MCOP's quality strategy; and

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

k. **Improvement Projects.** For the purposes of this Agreement, ODM defines "improvement projects" as projects using rapid-cycle continuous quality improvement methods to identify and address root causes of poor outcomes which prioritize and test interventions, monitor intervention results, and sustain and scale up interventions found through testing to improve health outcomes, quality of life, and satisfaction of providers and consumers.

MCP leadership shall sponsor improvement projects by regularly monitoring project progress and assigning appropriate staffing resources as described in this appendix. In addition to operationalizing the MCOP's improvement strategy, improvement projects shall be designed and implemented to build confidence among internal and external customers regarding the MCOP's commitment to population health and focus on continuous improvement of services and outcomes.

The MCOP shall evaluate all improvement projects, interventions, and initiatives and integrate the results into its overall quality assessment and improvement program.

The MCOP shall use ongoing analysis, data feedback, and the associated learning to determine improvement subjects and interventions. Knowledge gained from successful and unsuccessful intervention testing within improvement projects, as well as project outcomes, shall be shared, as specified by ODM, across MCOPs and with ODM to improve population health planning statewide.

l. **Performance Improvement Projects.** In accordance with 42 CFR 438.330, the MCOP shall conduct clinical and non-clinical performance improvement projects (PIPs) using rapid cycle quality improvement science techniques. The MCOP shall adhere to ODM-specified reporting, submission and frequency guidelines during the life of the PIP, and establish and implement mechanisms for sustaining successful interventions and maintaining improvement gains.

i. Upon request, the MCOP shall also provide longitudinal data demonstrating sustained improvement following the final validation of the PIP by ODM's external quality review organization (EQRO). The MCOP shall initiate and complete PIPs in topics selected by ODM. All PIPs designed and implemented by the MCOP shall be approved by ODM.

ii. The EQRO will assist the MCOP with the development and implementation of at least

one PIP by providing technical assistance, and will annually validate the PIPs in accordance with the Centers for Medicare and Medicaid Services' protocols.

m. **Quality Improvement Projects and Chronic Condition Improvement Projects**. Quality Improvement Projects (QIPs) and Chronic Condition Improvement Projects (CCIPs) use rapid cycle quality improvement science principles and may be required by the state or initiated by the MCOP. Like PIPs, the QIPs and CCIPs 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 MCOP shall adhere to ODM-specified reporting and submission requirements. The MCOP shall actively participate in all improvement initiatives facilitated by ODM, the EQRO, or both. This includes improvement projects focused on each population stream, MCOP support of primary care practices, and efforts with other state agencies, quality collaboratives and community based organizations impacting MCOP membership. MCOP participation shall also be required in ODM-directed population health efforts that require collaboration between all MCOPs and may include standardization of program processes across plans.

n. **Program Communication.** Each MCOP shall have a clearly defined communication strategy for quality improvement activities. This includes:

   i. Mechanisms for data receipt and exchange, analyzing and interpreting data, and transparently and proactively involving stakeholders and partners in applying data to improvement efforts;

   ii. A description, including lines and methods of communication, of the internal mechanisms used to frequently, transparently, and proactively communicate improvement status updates and results across the organization and to executive leadership;

   iii. Mechanisms for proactive, regular communication with ODM and/or EQRO staff regarding improvement opportunities and priorities, intervention successes, lessons learned, and future activities; and

   iv. Responding promptly and transparently to data and information requests by ODM or the EQRO.

o. **Clinical Practice Guidelines.** The MCOP's QAPI shall describe how the MCOP will ensure that the clinical practice guidelines are valid and represent reliable clinical evidence or a consensus of healthcare professionals in a particular field. MCOPs shall follow the guidance in the QAPI submission template when describing this aspect of the program.

p. **Assessment of Health Care Service Utilization.** The MCOP shall have mechanisms in place to detect under- and over-utilization of health care services. The MCOP shall follow the guidance in the QAPI submission template when specifying the mechanisms used to monitor utilization in the submission of the QAPI program to ODM. The MCOP shall ensure the utilization analysis documented in the QAPI is linked to ensuring population health outcomes, and is incorporated

into the quality strategy.

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

ii. The MCOP shall conduct an ongoing review of service denials and shall monitor utilization on an ongoing basis in order to identify services which may be underutilized.

q. **Assessment of the Quality and Appropriateness of Care for Members with Special Health Care Needs and Enrollees Receiving Long-term Services and Supports.** The MCOP shall have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. MCOPs shall follow the guidance in the QAPI submission template when describing and evaluating these aspects of the program.

r. **Addressing Health Disparities.** The MCOP shall participate in, and support, ODM's efforts to eliminate health disparities in Ohio. According to the U.S. Department of Health and Human Services' Office of Minority Health, and for the purposes of this Agreement, a health disparity is "a particular type of health difference closely linked with social or economic disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location).

i. In support of ODM's effort to achieve health equity, the MCOP shall collect and meaningfully use member-identified race, ethnicity, and language data to identify and reduce disparities in health care access, services, and outcomes. This includes, where possible, stratifying HEDIS and CAHPs, and Health Risk Assessment results by race, ethnicity, or other relevant demographics, and implementing a strategy to reduce identified disparities.

ii. The MCOP shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Medicaid-insured individuals and from providers of direct services which are intended to reduce adverse health outcomes among Medicaid insured individuals, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts.

s. **Submission of Performance Measurement Data.** The MCOP shall submit data as required by ODM that enables ODM to calculate standard measures as defined in Appendices L and M. The MCOP shall also submit self-reported, audited Healthcare Effectiveness Data and Information Set (HEDIS) data (see ODM Methodology for MCOP Self-Reported, HEDIS-Audited Data) for performance measures set forth in Appendix M. A separate, duplicative submission of

performance measurement data is not required as part of the annual QAPI submission.

t. **QAPI Program Impact and Effectiveness.** The MCOP shall evaluate the impact and effectiveness of each effort within the QAPI program, including efforts to reduce health disparities. The MCOP shall update the QAPI program based on the findings of the self-evaluation and submit both the evaluation results and updates annually to ODM for review and approval following the template provided in the QAPI guidance document. Evaluation should, at a minimum, include:

i. The outcomes and trended results of each improvement project, including documentation of successful and unsuccessful interventions;

ii. The results of any efforts to support community integration for enrollees using long-term services and supports; and

iii. How these results will be incorporated into the MCOP's quality strategy.

3. **External Quality Review.** The MCOP shall participate in annual external quality review activities. The review will include but not be limited to the following activities:

a. Administrative compliance assessment as required by 42 CFR 438.358 and as specified by ODM.

b. **Non Duplication Exemption**. In accordance with 42 CFR 438.360 and 438.362, an MCOP 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 MCOP when a non-duplication exemption may be requested.

c. The EQRO may conduct focused reviews of MCOP performance in the following domains which include, but are not limited to:

i. Availability of services;

ii. Assurance of adequate capacity and services;

iii. Coordination and continuity of care;

iv. Coverage and authorization of services;

v. Credentialing and re-credentialing of services;

vi. Sub contractual relationships and delegation;

vii. Enrollee information and enrollee rights;

viii. Confidentiality of health information;

ix. Enrollment and disenrollment;

x. Grievance process;

xi. Practice guidelines;

xii. Quality assessment and performance improvement program;

xiii. Health information systems;

xiv. Fraud and abuse;

xv. Encounter data studies;

xvi. Validation of performance measurement data;

xvii. Review of information systems;

xviii. Validation of performance improvement projects; and

xix. Member satisfaction and/or quality of life surveys.

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

APPENDIX L

DATA QUALITY

A high level of performance on the data quality standards and requirements established in this appendix is crucial in order for the Ohio Department of Medicaid (ODM) to determine the value of the MyCare Ohio Program and to evaluate MyCare Ohio members' access to and quality of services. Encounter data collected from the MyCare Ohio Plans (MCOPs) is used in key performance assessments, such as: the external quality review, clinical performance measures, utilization review, care coordination and care management, and in determining quality withholds. The data will also be used in conjunction with the cost reports in setting the capitation rates. The Encounter Data Volume measures, as specified in this appendix, will be calculated separately per MCOP for all MyCare Ohio members receiving services from the MCOP. These measures will be calculated for Medicaid services for all MyCare Ohio members (opt-in and opt-out populations combined), and for Medicare services for the dual benefit members (opt-in population). All other encounter data quality measures, as specified in this appendix, will be calculated for each MCOP: Rejected Encounters, Acceptance Rate, Encounter Data Accuracy Study measure (Payment Accuracy), Incomplete Rendering Provider Data, NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers, and Timeliness of Encounter Data Submission.

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

1. **Encounter Data.** For detailed descriptions of the encounter data quality measures below, see *ODM Methods for the MyCare Ohio Encounter Data Quality Measures*. The MCOP's encounter data submissions will be assessed for completeness and accuracy per Section 2 of the Three-Way. The MCOP shall collect information from providers and report the data to ODM in accordance with program requirements established in Appendix C.

    a. **Encounter Data Completeness.**

        i. **Encounter Data Volume.**

            1. **Measure**. The volume measure for each service category, as listed in the tables below, is the rate of utilization (e.g., admits, visits) per 1,000 member months (MM).

            2. **Report Period**. The report periods for SFY 2020 and SFY2021 contract periods are listed in Table 1 below. Only the standards for Medicaid services, as shown in Table 2 below, will be used to assess compliance beginning measurement period Qtr 3: 2018. The previous measurement periods are for informational purposes only. Standards for Medicare services as shown in Table 3 will be used for informational purposes only. The measure methodology has been revised to better align with Cost Report category of service methodology.

Table 1. Report Periods for Relevant SFY 2020 and SFY 2021 Contract Periods – Encounter Data Volume.

MCOP Quarterly Report Periods	Data Source (Estimated Encounter Data File Update)	Quarterly Report Estimated Issue Date	Contract Period
Qtr 3: 2018 – Qtr 4: 2018	July 2019	August 2019	SFY 2020
Qtr 3: 2018 – Qtr 1: 2019	September 2019	October 2019	
Qtr 3: 2018 – Qtr 2: 2019	December 2019	January 2020	
Qtr 3: 2018 – Qtr 3: 2019	March 2020	April 2020	
Qtr 3: 2018 – Qtr 4: 2019	June 2020	July 2020	SFY 2021
Qtr 4: 2018 – Qtr 1: 2020	September 2020	October 2020	
Qtr 1: 2019 – Qtr 2: 2020	December 2020	January 2021	
Qtr 2: 2019 – Qtr 3: 2020	March 2021	April 2021	

Qtr1 = January to March; Qtr2 = April to June; Qtr3 = July to September; Qtr 4 = October to December

3. **Data Quality Standards.** The data quality standards for the encounter data volume measure for Medicaid and Medicare services are listed in Tables 2 and 3 below, respectively. The MCOP's utilization rate for each service category listed in Tables 2 and 3 shall be equal to or greater than the associated standard established for each service category in Tables 2 and 3, in all quarters of the measurement period.

Table 2. All MyCare Members (Opt-In and Opt-Out) Medicaid Services Standards – Encounter Data Volume.

Category of Service	Utilization per 1,000 MM Threshold				
	Aetna	Buckeye	CareSource	Molina	United
Behavioral Health	302.0	255.8	424.5	339.1	278.9
Outpatient	312.6	411.9	382.9	271.3	447.6
Inpatient	27.4	26.9	26.8	20.5	23.7
Primary & Specialist Care	1886.2	1639.1	1320.5	1116.7	1440.1
Vision	39.2	37.1	44.3	30.5	35.8
Dental	36.1	44.6	35.5	45.3	40.9
Long Term Care	159.1	135.7	124.0	153.1	164.7
Pharmacy	TBD	TBD	TBD	TBD	TBD
Home Health	TBD	TBD	TBD	TBD	TBD
Waiver	3321.7	3570.0	3950.5	2558.3	3464.4

Table 3. Dual Benefit Members (Opt-In) Medicare Services for Informational Purpose Only – Encounter Data Volume.

Category of Service	Utilization per 1,000 MM Threshold				
	Aetna	Buckeye	CareSource	Molina	United
Behavioral Health	60.9	49.5	113.0	55.1	301.5
Outpatient	461.7	472.8	445.8	385.5	511.7
Inpatient	29.0	29.7	28.2	27.6	24.2
Primary & Specialist Care	1423.6	1400.3	1208.4	1417.4	1538.9
Vision	24.7	25.6	42.5	41.7	27.6
Long Term Care	48.7	54.9	113.9	47.6	214.0
Pharmacy	NR	NR	NR	NR	NR

ii. **Incomplete Rendering Provider Data.** This measure is calculated per MCOP and includes all Ohio MCOP members receiving services from the MCOP. The *Incomplete Rendering Provider Data* measure is calculated to ensure the MCOP is reporting individual-level rendering provider information to ODM, so that ODM complies with federal reporting requirements.

1. **Measure.** The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in the Medicaid Information Technology System (MITS).

2. **Report Period.** The report periods for SFY 2020 contract periods are listed in Table 4 below. The MCOP shall meet or exceed the standard in all quarters of the report period. This measure will be used for informational purposes only until September 2019 report. Beginning in September 2019, this measure will be used to determine compliance.

3. **Data Quality Standard.** Less than or equal to 6.0%.

Table 4. SFY 2020 and SFY 2021 Contract Periods

Quarterly Measurement Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1: 2019	September 2019	October 2019	SFY 2020
Qtr 1 thru Qtr 2 2019	December 2019	January 2020	
Qtr 1 thru Qtr 3 2019	March 2020	April 2020	
Qtr 1 thru Qtr 4 2019	June 2020	July 2020	SFY 2021
Qtr 1: 2019 thru Qtr 1: 2020	September 2020	October 2020	
Qtr 1: 2019 thru Qtr 2: 2020	December 2020	January 2021	
Qtr 1: 2019 thru Qtr 3: 2020	March 2021	April 2021	

iii. **Incomplete Billing Provider Data.** This measure is calculated per MCOP and includes all Ohio MCOP members receiving services from the MCOP. The *NPI Provider Number Usage without Medicaid/Reporting Provider Numbers* measure is calculated to ensure

providers reported on encounters can be associated with Medicaid and/or Reporting providers in MITS.

1. **Measure.** The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data field that do not have a Medicaid or Reporting Provider Number in MITS.

2. **Report Period.** The report periods for SFY 2020 contract periods are listed in Table 4 above. Prior SFY data will be used as a baseline to set performance standard. The MCOP shall meet or exceed the standard in all quarters of the report period. This measure will be used for informational purposes only until September 2019 report. Beginning in September 2019, this measure will be used to determine compliance.

3. **Data Quality Standard.** Less than or equal to 6.0%

iv. **National Provider Identifier (NPI) for Ordering, Referring, and Prescribing (ORP) Providers.** The MCOP must require an ORP provider's NPI on a claim for any service that requires an order, referral, or prescription. The NPI for ORP Providers measure is calculated to ensure these providers reported on encounters can be verified by ODM in compliance with 42 CFR § 438.602 and 42 CFR § 455.410. This measure is calculated per MCOP and includes all members receiving services from the MCOP.

1. **Measure.** Percentage of EDI transactions with qualifying billing provider types and specialties with an NPI provider number in the ORP provider EDI data field that do not pass as having a valid NPI.

   The following individual providers are eligible to order, refer, or prescribe within the Medicaid program and within their scope of practice:

   - Physicians;
   - Advanced Practice Registered Nurses;
   - Psychologists;
   - Podiatrists;
   - Optometrists;
   - Dentists;
   - Chiropractors; and
   - Physician Assistants

   ORP requirements apply to all claims submitted by the following provider types:

   - Other Accredited Home Health Agencies;
   - Private duty nurses;
   - Hospice;

- Clinics (DME, Skilled Therapy, Clinical Laboratory, or Radiology Imaging services only);
- Mental Health Clinics (DME, Skilled Therapy, Clinical Laboratory, or Radiology Imaging services only);
- Medicare Certified Home Health Agencies;
- Skilled Therapists;
- Clinical Nurse Specialists;
- Pharmacies;
- Durable Medical Equipment Suppliers;
- Imaging\Testing Facilities;
- Independent Laboratories;
- Portable X-Ray Suppliers;
- Nursing Facilities (DME, Skilled Therapy, Clinical Laboratory, or Radiology Imaging services only); and
- Federally Qualified Health Centers – Skilled Therapies.

2. **Measurement Period.** The reporting periods for the current contract period are listed in Table 5 below. Results for CY2019 will be informational only. This measure will be used for informational purposes until CY2020. This measure will be used to determine compliance in the near future.

Table 5. SFY 2020 and SFY 2021 Contract Periods

Quarterly Measurement Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1 2019	TBD	TBD	SFY 2020
Qtr 1 thru Qtr 2 2019	TBD	TBD	
Qtr 1 thru Qtr 3 2019	TBD	TBD	
Qtr 1 thru Qtr 4 2019	TBD	TBD	SFY 2021
Qtr 1: 2019 thru Qtr 1: 2020	TBD	TBD	
Qtr 1: 2019 thru Qtr 2: 2020	TBD	TBD	
Qtr 1: 2019 thru Qtr 3: 2020	TBD	TBD	

3. **Data Quality Standard.** TBD

v. **Rejected Encounters.** Encounters submitted to ODM that are incomplete or inaccurate are rejected and reported back to the MCOP on the Exception Report. MCOPs must resubmit rejected encounters.

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

1. **Measure.** The percentage of encounters submitted to ODM that are rejected.

2. **Measurement Period.** For the SFY 2020 contract period, performance will be evaluated using the following measurement periods: January-March 2020 and April – June 2020.

3. **Data Quality Standard.** The data quality standard for this measure is a maximum data rejection rate for each file type in the ODM-specified format as follows:

837 Dental	25%
837 Institutional	20%
837 Professional	20%
NCPDP Pharmacy	20%

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

vi. **Acceptance Rate.** This measure only applies to an MCOP that has had MCOP membership for one year or less.

1. **Measure.** The rate of encounters submitted to ODM and accepted (i.e. accepted encounters per 1,000 member months).

2. **Measurement Period.** The measurement period for this measure is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

3. **Data Quality Standard.** The data quality standard is a monthly minimum accepted rate of encounters for each file type in the ODM-specified medium per format as follows:

c. **Third through sixth month with membership**: Not Applicable for SFY 2017.

b. **Seventh through twelfth month of membership**: Not Applicable for SFY 2017.

d. **Encounter Data Accuracy Study.** The MCOP shall ensure collection and submission of accurate data to ODM. Failure to do so jeopardizes MCOP performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

i. **Measure.** This accuracy study will compare the accuracy and completeness of payment data stored in MCOP claims systems during the study period to payment data submitted to and accepted by ODM. The measure will be calculated per MCOP. 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). At a minimum, the additional components of analysis will include diagnosis codes and provider information (e.g., rendering provider, billing provider).

ii. **Encounter Data Completeness (Level 1).**

1. **Omission Encounter Rate.** The percentage of encounters in the MCOP's fully adjudicated claims file not present in the ODM encounter data files.

2. **Surplus Encounter Rate.** The percentage of encounters in the ODM encounter data files not present in the MCOP's fully adjudicated claims files.

iii. **Payment Data Accuracy (Level 2).**

1. **Payment Error Rate.** The percentage of matched encounters between the ODM encounter data files and the MCOP's fully adjudicated claims files where a payment amount discrepancy was identified.

2. **Report Period.** In order to provide timely feedback on the omission rate of encounters, the report period will be the most recent from when the study is initiated. This study is conducted annually.

iv. **Data Quality Standards.**

1. For CY 2015.

   a. **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.

   b. **For Level 2**. A payment error rate of no more than 4%.

2. For CY 2016.

   a. **For Level 1.** An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.

   b. **For Level 2.** A payment error rate of no more than TBD.

3. For CY 2017.

   a. **For Level 1.** An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.

b. **For Level 2.** A payment error rate of no more than TBD.

4. For CY 2018.

a. **For Level 1.** An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.

b. **For Level 2.** A payment error rate of no more than TBD.

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

Information concerning MyCare Ohio encounter data measures may be obtained from the Ohio Department of Medicaid's Methodology for MyCare Ohio Encounter Data Quality Measures document also located on the ODM website. This document gives additional guidance on the methodologies used to create the measures in Appendix L of this Agreement. This document also provides the MyCare Encounter Data Minimum Number of Encounters required by each plan, the MyCare Encounter Data Submission Schedule, and the MyCare Encounter Data Certification Letter guidelines.

i. **Encounter Data Submission Procedure.** The MCOP shall submit encounter data files to ODM per the specified schedule and within the allotted amount established in ODM's Methodology for MyCare Ohio Encounter Data Quality Measures document.

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

The letter of certification shall be signed by the MCOP'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 MCOP's CEO or CFO.

ii. **Required Monthly Minimum Number of Encounters Accepted Into MITS.** The information in Table 4 is a baseline measure from ODM MyCare encounter reports from July 2016 through December 2016.

1. **Measure.** The percentage of the number of required monthly encounters accepted into MITS per Table 4.

2. **Measurement Periods.** For SFY2020: July 2019, August 2019, September 2019, October 2019, November 2019, December 2019, January 2020, February 2020,

March 2020, April 2020, May 2020, and June 2020.

3. **Data Quality Standard.** The data quality standard is equal or greater than 100%.

Table 6. Baseline Measure from ODM MyCare Encounter Reports.

Managed Care Plan	Required Number of Institutional and Professional	Required Number of Pharmacy NCPDP	Required Number of Dental
CareSource	145,000	93,000	250
United Health Care	138,000	73,000	250
Molina	94,000	58,000	250
Buckeye	124,000	54,000	250
Aetna	120,000	74,000	250

2. **MCOP Self-Reported, Audited HEDIS Data.**

   a. **Annual Submission of HEDIS IDSS Data.** The MCOP is required to collect, report, and submit to ODM self-reported, audited HEDIS data for the full set of HEDIS measures reported by the MCOP to NCQA for MyCare Ohio members per *ODM's Specifications for the Collection and Submission of MyCare Ohio Self-Reported, Audited HEDIS Results*. The self-reported, audited HEDIS data are due to ODM no later than five business days after the NCQA due date.

   b. **Annual Submission of Final HEDIS Audit Report (FAR).** The MCOP is required to submit to ODM its FAR that contains the audited results for the full set of HEDIS measures reported by the MCOP to NCQA for MyCare Ohio members. This shall include all HEDIS measures referenced in Appendix M. The FAR is due to ODM no later than five business days after the NCQA due date.

      Note: ODM will review the MCOP'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" (NR) for any measure. ODM reserves the right to pursue corrective action based on this review.

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

      Each data certification letter is due to ODM on the same days the respective HEDIS IDSS data/ FAR are submitted to ODM. Additional specifications regarding the data certification letters will be made available in future technical guidance.

3. **Care Management Data.** The MCOP shall submit care management data in accordance with the *MyCare Ohio Care: Population Stream, Risk Stratification Data, and Care Management Status*

Submission Specifications.

In accordance with 42 CFR 438.600—438.606, each MCOP shall sign and submit the ODM required data certification letter to ODM attesting to the accuracy and completeness of care management data submitted to ODM.

4. **Appeals and Grievances Data.** Pursuant to OAC rule 5160-58-08.4, the MCOP is required to submit appeal and grievance activity to ODM as directed. ODM requires appeal and grievance activity to be submitted at least monthly in an electronic data file format pursuant to the *Appeal File and Submission Specifications* and G*rievance File and Submission Specifications*.

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

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

5. **Utilization Management Data.** Pursuant to OAC rules 5160-58-01.1 and 5160-26-03.1, the MCOP is required to submit information on prior authorization requests as directed by ODM. ODM requires information on prior authorization requests to be submitted in an electronic data file formats pursuant to the *Utilization Management Tracking Database: Prior Authorization File and Submission Specifications* document.

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

6. **Health Outcomes Survey (HOS) Data.** The MCOP is required to collect, report, and submit HOS data to CMS on an annual basis for applicable MyCare Ohio members per CMS' *Reporting Requirements for HEDIS, HOS and CAHPS Measures*.

7. **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Data.** The MCOP is required to collect, report, and submit CAHPS data to CMS on an annual basis for applicable MyCare Ohio members per *CMS' Reporting Requirements for HEDIS, HOS, and CAHPS Measures.*

8. **Timely Submission of Nursing Facility 100-Day Threshold and Discharge Data.** The MCOP is required to collect, report, and submit nursing facility 100-day threshold and discharge data as specified in the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement*. Individual member records shall be submitted within 30 business days of the NF LOC (100-day threshold) date and date of discharge, and in every case, NF LOC (100-day threshold) dates shall be submitted in accordance with dates specified by ODM to comply with the MEMA timeframes specified in Appendix E.

   The individual member records 100-day threshold and discharge dates shall be complete and

accurate as compared with associated medical records and in accordance with the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement.*

The MCOP shall also submit a letter of certification, using the form required by ODM, with each nursing facility admission and discharge data submission file. ODM will use a sample of the NF LOC data to determine compliance.

9. **MyCare Ohio Quarterly Enrollment Files.** Accurate and complete MCOP enrollment records are a critical component of determining accurate rates for measures where member enrollment is used as the basis for calculating rates. In order to ensure the most accurate and complete enrollment records possible for the MCOP, ODM is creating quarterly enrollment files to be sent to the MCOP for the purpose of enrollment verification. Details regarding specifications for these enrollment files can be found in *ODM's MyCare Ohio Plan Quarterly Enrollment Data File Specifications.*

   The MCOP may voluntarily submit to ODM on a quarterly basis addition and deletion files for member enrollment spans. These file submissions shall be accompanied by a data certification letter, using the form required by ODM. Specifications for submitting the addition and deletion files, and instructions for submitting the associated data certification letter, are provided in ODM's *MyCare Ohio 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 MCOP files submitted under this section that are not accompanied by the associated data certification letter.

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

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

APPENDIX M

QUALITY & WAIVER PERFORMANCE MEASURES AND STANDARDS

The Ohio Department of Medicaid (ODM) has established Quality and Waiver Performance Measures and Standards to evaluate MyCare Ohio Plan (MCOP) performance in key program areas (i.e., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and focus areas of the ODM Quality Strategy. Each measure has a Minimum Performance Standard. Failure to meet a Minimum Performance Standard will result in the assessment of a noncompliance penalty. See Appendix N of this Agreement for sanctions for noncompliance with the performance standards.

The quality measures utilized for performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ, HOS, CAHPS, MDS, CMS, etc.), widely used for evaluation of Medicaid/Medicare managed care industry data, or are Ohio-specific measures designed to monitor goals associated with rebalancing initiatives which provide greater access to home and community based services, as an alternative to facility-based long-term care. Each measure applies to dual benefit members (opt-in population) and/or to Medicaid-only members (opt-out population). Quality and Waiver 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 performance measures listed in this appendix are not intended to limit the assessment of other indicators of performance for quality improvement activities. MCOP performance based on multiple measures will be assessed and reported to the MCOP and others, including Medicare and Medicaid consumers.

1. **Quality Measures and Standards.** The MCOP is evaluated on measures separately for dual benefit members (opt-in population) and Medicaid-only members (opt-out population) using statewide population-specific results that include all regions in which the MCOP has membership. Results for each measure are calculated per MCOP and will either include all of the MCOP's Ohio dual benefit members (opt-in population) and/or Medicaid-only (opt-out population) per the criteria specified by the methodology for the given measure. Separate minimum performance standards may be established for the dual benefit population and the Medicaid-only population.

    a. **Measurement Data.** MCOP performance is assessed using ODM calculated performance measurement data, CMS calculated performance measurement data, and results submitted to ODM and CMS by the MCOP. The measures in this appendix are calculated in accordance with CMS' Reporting Requirements for HEDIS, HOS, and CAHPS Measures, and *The Ohio Department of Medicaid's MyCare MDS Quality Measures Methods.*

    b. **Measures, Measurement Sets, Standards, and Measurement Years.** The measures and accompanying Minimum Performance Standards and measurement years for the SFY 2018, SFY 2019, SFY 2020 and SFY 2021 contract periods are listed in Table 1. below. Each measure's corresponding measurement set and applicable consumer population is also provided.

Table 1. SFY 2018, SFY 2019, SFY 2020 and SFY 2021, Performance Measures, Measurement Sets, Standards, and Measurement Years

Quality Strategy: Population Stream	Measure	Measurement Set	Applicable Population	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year	SFY 2020 Minimum Perf. Std.	SFY 2020 Measurement Year	SFY 2021 Minimum Perf. Std.	SFY 2021 Measurement Year
Behavioral Health	Follow-up After Hospitalization for Mental Illness -30 Day Follow Up*	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	≥56.0%	CY 2017	≥56.0%	CY 2018	QW	CY 2019	QW	CY 2020
Behavioral Health	Antidepressant Medication Management	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	Effective Acute Phase Treatment ≥ 64.1% Effective Continuation Phase Treatment ≥ 48.4%	CY 2017	Effective Acute Phase Treatment ≥ 63.45% Effective Continuation Phase Treatment ≥ 47.10%	CY 2018	Effective Acute Phase Treatment ≥64.43% Effective Continuation Phase Treatment ≥49.00%	CY 2019	Effective Acute Phase Treatment ≥ TBD Effective Continuation Phase Treatment ≥ TBD	CY 2020
Chronic Conditions	Controlling High Blood Pressure*	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	≥53.0%	CY 2017	≥56.0%	CY 2018	QW	CY 2019	QW	CY 2020
Chronic Conditions	Comprehensive Diabetes Care - HbA1c Control (<8.0%)	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	≥55.8%	CY 2017	≥55.85%	CY 2018	≥58.64%	CY 2019	≥ TBD	CY 2020
Chronic Conditions	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)**	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	Not Applicable		Not Applicable		Not Applicable		QW	CY 2020
Chronic Conditions	Comprehensive Diabetes Care – Eye Exam	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	Not Applicable		Not Applicable		Not Applicable		Reporting Only	CY 2020
Chronic Conditions	Part D Medication Adherence for Diabetes Medications*	CMS	Dual Benefits Members (Opt-In)	≥ 73.0%	CY 2017	≥ 73.0%	CY 2018	QW	CY 2019	QW	CY 2020
Healthy Adults	Annual Flu Vaccine*	CAHPS	Dual Benefits Members (Opt-In)	≥69.0 %	CY 2017 (Survey conducted in CY 2018)	≥69.0 %	CY 2018	QW	CY 2019	QW	CY 2020
Healthy Adults	Fall Risk Management – Managing Fall Risk	NCQA/ HEDIS/ HOS	Dual Benefits Members (Opt-In)	≥55.0%	CY 2017 (Survey conducted	Reporting Only	CY 2018	Reporting Only	CY 2019	Reporting Only	CY 2020

					in CY 2018)						
Healthy Adults	Breast Cancer Screening	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	≥66.3%	CY 2017	≥66.37%	CY 2018	≥66.84%	CY 2019	≥ TBD	CY 2020
Healthy Adults	Medication Reconciliation Post Discharge**	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	Not Applicable		Not Applicable		Not Applicable		QW	CY 2020
Healthy Adults	Colorectal Cancer Screening***	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	Not Applicable		Not Applicable		Not Applicable		QW	CY 2020
Integrating Care	Plan All Cause Readmissions – Observed Readmissions (Num/Den)	CMS	Dual Benefits Members (Opt-In)	≤ 11.0%	CY 2017	Eliminated Effective SFY 2019	Eliminated Effective SFY 2019	Eliminated Effective SFY 2019	Eliminated Effective SFY 2019	Eliminated Effective SFY 2019	Eliminated Effective SFY 2019
	Plan All Cause Readmissions – observed-to-expected (O/E) ratio*	CMS	Dual Benefits Members (Opt-In)	N/A	N/A	≤ 1.00	CY 2018	QW	CY 2019	QW	CY 2020
	Adults' Access to Preventive/ Ambulatory Health Services	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	≥ 93.8%	CY 2017	≥ 93.72%	CY 2018	≥ 93.70%	CY 2019	≥ TBD	CY 2020
	Getting Appointments and Care Quickly Composite	CAHPS	Dual Benefits Members (Opt-In)	≥ 73.0%	CY 2017 (Survey conducted in CY 2018)	≥ 76.0%	CY 2018	≥ 74.0%	CY 2019	≥ TBD	CY 2020
	Satisfaction with Customer Service Composite	CAHPS	Dual Benefits Members (Opt-In)	≥ 86.0%	CY 2017 (Survey conducted in CY 2018)	≥ 89.0%	CY 2018	≥ 88.3%	CY 2019	≥ TBD	CY 2020
	Care for Older Adults - Medication Review, 66 & Older	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	≥57.0%	CY 2017	≥60.0%	CY 2018	≥ 69.0%	CY 2019	≥ TBD	CY 2020
	Care for Older Adults - Functional Status Assessment, 66 & Older	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	≥56.0%	CY 2017	≥59.0%	CY 2018	≥ 67.0%	CY 2019	≥ TBD	CY 2020
	Care for Older Adults - Pain Assessment , 66 & Older	NCQA/ HEDIS	Dual Benefits Members (Opt-In)	≥59.0%	CY 2017	≥60.0%	CY 2018	≥ 62.0%	CY 2019	≥ TBD	CY 2020
Improving and Rebalancing	Percent of residents whose need for help with	RTI International/ MDS	Dual Benefits Members (Opt-	≤ 17.6%	CY 2017	≤ 17.6%	CY 2018	≤ 17.6%	CY 2019	≥ TBD	CY 2020

Long- Term Care	daily activities has increased		In) and Medicaid- Only Members (Opt-Out)								
	Percent of residents who were physically restrained	RTI International/ MDS	Dual Benefits Members (Opt-In) and Medicaid - Only Members (Opt-Out)	≤ 2.1%	CY 2017	≤ 2.1%	CY 2018	≤ 2.1%	CY 2019	≥ TBD	CY 2020
	Percent of residents experiencing one or more falls with a major injury	RTI International/ MDS	Dual Benefits Members (Opt-In) and Medicaid - Only Members (Opt-Out)	≤ 3.6%	CY 2017	≤ 3.6%	CY 2018	≤ 3.6%	CY 2019	≥ TBD	CY 2020
	Percent of residents with urinary tract infection	RTI International/ MDS	Dual Benefits Members (Opt-In) and Medicaid - Only Members (Opt-Out)	≤ 5.8%	CY 2017	≤ 5.8%	CY 2018	≤ 5.8%	CY 2019	≥ TBD	CY 2020
	Percent of high-risk residents with pressure ulcers	RTI International/ MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 5.6%	CY 2017	≤ 5.6%	CY 2018	≤ 5.6%	CY 2019	≥ TBD	CY 2020
	Percent of residents who have/had a catheter inserted and left in their bladder	RTI International/ MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 3.0%	CY 2017	≤ 3.0%	CY 2018	≤ 3.0%	CY 2019	≥ TBD	CY 2020

*Quality withhold measure for Demonstration Years 2 (CY 2016), 3 (CY 2017), 4 (CY 2018), 5 (CY 2019) and 6 (CY2020).
** Quality withhold measure for Demonstration Year 6 (CY2020).
***Alternative quality withhold measure for Demonstration Year 6 (CY2020).

2. **Waiver Performance Measure.** ODM must submit evidence to CMS regarding the State's ability to adhere to the six federal assurances for operating a Home and Community Based (1915c) waiver annually. The six assurances include level of care, service planning, qualified providers, health and welfare, financial accountability, and administrative authority. There are thirty-four waiver performance measures across the six waiver assurances. CMS established a minimum threshold of 86% per measure.

If the threshold is not achieved, ODM is subject to a CMS-issued corrective action plan.

To align with federal requirements, the MCOP must achieve a minimum performance standard of 86% for each measure. Eighteen of the thirty-four waiver measures are dependent on the MCOP's performance (listed in Table 2). Failure to meet the minimum performance standard may result in the assessment of a noncompliance penalty. See Appendix N of this Agreement for sanctions for noncompliance with the performance standard.

a. **Measure.** Percentage calculated for each HCBS waiver performance measure.

b. **Measurement Periods:** Beginning in CY 2020, and then each calendar year thereafter, the measurement period for each measure specified in Table 2 below will be data from the previous calendar year.
c. **Minimum Performance Standard:** 86%.

Table 2. Waiver Performance Measures.

Performance Measure	Source
Number and percent of required reports submitted by the MCOPs in a complete and timely manner.	MCOP
Number and percent of findings of MCOP plans' noncompliance that were remediated through an approved corrective action plan or other method as required by the OMA/MCOP provider agreement.	MCOP / ODM Contract Admin
Number and percent of MCOP waiver participants reviewed whose waiver service plans adequately address their assessed needs.	EQRO
Number and percent of MCOP waiver participants reviewed whose waiver service plan have strategies to address and mitigate their health and welfare risks factors.	EQRO
Number and percent of waiver service plans reviewed that address individuals' personal goals	EQRO
Number and percent of MCOP waiver participants reviewed whose waiver service plans were updated at least once in the past twelve months.	EQRO
Number and percent of sampled MCOP waiver participants whose service plans were revised, as needed, to address changing needs.	EQRO
Number and percent of MCOP waiver participants reviewed who received services in the type, scope, amount and frequency specified in the service plan.	EQRO
Number and percent of the MCOP waiver participants reviewed whose records contained a document signed by the participant to indicate their choice to receive waiver services instead of institutional care.	EQRO
Number and percent of incident reviews/investigations for MCOP Waiver participants that were initiated as specified in the waiver.	ODM Record Reviews
The number and percent of incident reviews/investigations for ICDS Waiver participants that were completed as specified in the waiver	ODM Record Reviews
Number and percent of participants reviewed with an incident who had a plan of prevention/documentation of a plan developed as a result of the incident.	ODM Record Reviews
Number and percent of reported incidents of unauthorized restraint, seclusion or other restrictive interventions that were reported and investigated as specified in the MCOP waiver.	ODM Record Reviews
Number and percent of sampled MCOP waiver participants reviewed for whom there was a back-up plan in place in the event providers do not show up.	EQRO

Number and percent of MCOP Waiver participants (and/or family members or legal guardians) reviewed who received information/education about how to report abuse, neglect, exploitation and other incidents as specified in the waiver.	EQRO
Number and percent of reported MCOP Waiver participant incidents investigated by the MCOP plans that were found to have been fully investigated and resolved.	ODM Record Reviews
Number and percent of claims verified through a review of provider documentation to have been paid in accordance with individuals' waiver service plans.	MCOP (Waiver service claims audit report)
Number and percent claims sampled in (the previous) performance measure that were found to be unsupported claims for waiver services for which payment was recouped.	MCOP (Waiver service claims audit report)

3. Notes.

a. **Measures and Measurement Periods.** ODM reserves the right to revise the measures and measurement periods referenced 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 an MCOP's performance level for that contract period.

b. **Performance Standards – Compliance Determination.** In the event an MCOP's performance cannot be evaluated for a performance measure and/or a measurement period referenced in this appendix, ODM will deem the MCOP to have met or to have not met the standard(s) for that particular measure and measurement period depending on the circumstances involved (e.g., if a HEDIS measure was assigned an audit result of "Not Report" on the MCOP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCOP, ODM would deem the MCOP to have not met the standard(s) for that measure and measurement period).

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 referenced in this appendix, except for the CAHPS measure standards. This methodology will be implemented at ODM's discretion.

d. For a comprehensive description of the standard adjustment methodology, see *ODM Methods for the Retrospective Adjustment of Quality, P4P and Quality Withhold Measure Standards, which may be amended if necessary upon agreement of both parties.*

The sanctions for non-compliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX N

COMPLIANCE ASSESSMENT SYSTEM

1. **General Provisions of the Compliance Assessment System.**

   a. The Compliance Assessment System (CAS) sets forth sanctions that may be assessed by the Ohio Department of Medicaid (ODM) against the MyCare Ohio Plan (MCOP) if the MCOP is found to have violated the Three-Way, this Agreement, or applicable law. It does not in any way limit ODM from requiring Corrective Action Plans (CAPs) and program improvements, or from imposing any of the sanctions specified in 42 CFR 438.706 and OAC rule 5160-26-10 (applicable to MyCare Ohio pursuant to OAC rule 5160-58-01.1) or any other additional compliance actions, including the proposed termination, amendment, or nonrenewal of this Agreement. Civil monetary penalties imposed by ODM in accordance with 42 C.F.R. 438.702(a)(1) shall not exceed the federal limits set forth in 42 C.F.R. 438.704.

   b. As set forth in OAC rule 5160-26-10, regardless of whether ODM imposes a sanction, the MCOP is required to initiate corrective action for any MCOP program violation or deficiency as soon as the violation or deficiency is identified by the MCOP or ODM. The MCOP 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 MCOP to deliver covered services, or affect the member's ability to access covered services.

   c. If ODM determines the MCOP has violated any of the requirements of Sections 1903(m) or 1932 of the Social Security Act that are not specifically identified within this Agreement, ODM may (1) require the MCOP to permit any of its members to disenroll from the MCOP without cause, or (2) suspend any further new member enrollments to the MCOP, or both.

   d. Program violations that reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time ODM first becomes aware of this noncompliance.

   e. ODM retains the right to use its discretion to determine and apply the most appropriate compliance action based on the severity of the noncompliance, a pattern of repeated noncompliance, and number of beneficiaries affected. In instances where the MCOP is able to document, to the satisfaction of ODM, the violation and precipitating circumstances were beyond its control and could not reasonably have been foreseen (e.g. a construction crew severs a phone line, a lightning strike disables a computer system, etc.), ODM may in its discretion utilize alternative methods (i.e. a remediating plan) in lieu of the imposition of sanctions/remedial actions as defined in this appendix.

f. A Remediation Plan is a structured activity or process implemented by the MCOP to improve identified deficiencies related to compliance with applicable rules, regulations or contractual requirements. All remediation plans shall be submitted in the manner specified by ODM. Failure to comply with, or meet the requirements of a remediation plan may result in the imposition of progressive sanctions/remedial actions outlined in Section II.

g. ODM will issue all notices of noncompliance in writing to the identified MCOP contact.

h. Actions recommended or issued by the Contract Management Team (CMT) as defined in the Three-Way in no way limit ODM's authority to impose sanctions and remedial actions under this Agreement. ODM will take into consideration any sanctions or actions taken by the CMT when deciding whether and what type of sanctions/remedial actions to take for violations of this Agreement.

2. **Types of Sanctions/Remedial Actions.** ODM may impose sanctions/remedial actions, including, but not limited to, the items listed below.

a. **ODM Initiated Corrective Action Plans (CAPs)**. A CAP is a structured activity, process or quality improvement initiative implemented by the MCOP to improve identified operational and clinical quality deficiencies. All CAPs shall be submitted in the manner specified by ODM.

The MCOP may be required to develop CAPs for any instance of noncompliance with applicable rules, regulations or contractual requirements; CAPs are not limited to actions taken in this appendix. All CAPs requiring ongoing activity on the part of the MCOP 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 shall be implemented by the MCOP or if the MCOP has failed to submit a CAP, ODM may require the MCOP to comply with an ODM-developed or "directed" CAP.

Where a sanction is assessed for a violation in which the MCOP has previously been assessed a CAP (or any sanction or any other related written correspondence), the MCOP may be assessed escalating sanctions.

b. **Financial Sanctions.**

i. **Financial Sanctions Assessed Due to Accumulated Points.** Points will accumulate over a rolling 12-month schedule. Points more than 12 months old will expire.

No points will be assigned for a violation if the MCOP is able to document the precipitating circumstances were completely beyond its control and could not reasonably have been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.).

In cases where the MCOP-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), ODM may assess points unless to the satisfaction of ODM: (1) the MCOP can document it provided sufficient notification or education to providers of applicable program requirements and prohibited activities; and (2) the MCOP took immediate and appropriate action to correct the problem and to ensure it will not reoccur. ODM will review repeated incidents and determine whether the MCOP has a systemic problem. If ODM determines a systemic problem exists, further sanctions or remedial actions may be assessed against the MCOP.

1. **5 Points.** ODM may in its discretion assess five 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 MCOP 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 point violations include, but are not limited to the following:

    a. Failure to provide accurate provider panel information.

    b. Failure to provide member materials to new members in a timely manner.

    c. Failure to comply with appeal, grievance**,** or state hearing requirements, including the failure to notify a member of his or her right to a state hearing when the MCOP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.

    d. Failure to staff a 24-hour call-in system with appropriate trained medical personnel.

    e. Failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.

    f. Provision of false, inaccurate or materially misleading information to ODM, health care providers, the MCOP's members, or any eligible individuals.

    g. Use of unapproved marketing or member materials.

    h. Failure to appropriately notify ODM, or members, of provider panel terminations.

i. Failure to update website provider directories as required.

j. Failure to comply with an open remediation plan or CAP or a CAP closed in the last 12 months.

k. Failure to meet provider network performance standards.

l. A violation of a care management process specified in Section 2.5.3 of the Three-Way, or Appendix K of this Agreement that does not meet the standards for a 10 point violation. Examples include but are not limited to the failure to:

    i. Ensure staff performing care management functions are operating within their professional scope of practice, are appropriately responding to a member's care management needs, or are complying with the state's licensure/credentialing requirements;

    ii. Adequately assess an individual's needs including the evaluation of mandatory assessment domains;

    iii. Update an assessment upon a change in health status, needs or significant health care event;

    iv. Develop or update a care plan that appropriately addresses assessed needs of a member;

    v. Monitor the care plan;

    vi. Complete a care gap analysis that identifies gaps between recommended care and care received by a member;

    vii. Update the care plan in a timely manner when gaps in care or change in need are identified;

    viii. Coordinate care for a member across providers, specialists, and team members, as appropriate;

    ix. Adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls;

    x. 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; or

xi. Adhere to home and community-based services (HCBS) waiver service coordination and operational requirements in Section 2.5.3.3.5.1 of the Three-Way, and the Ohio approved HCBS 1915(c) waiver for MyCare Ohio.

2. **10 Points.** ODM may in its discretion assess ten points for any instance of noncompliance with applicable rules, regulations or contractual requirements that could, as determined by ODM: (1) affect the ability of the MCOP to deliver, or a member to access, covered services; (2) place a member at risk for a negative health outcome; or (3) jeopardize the safety and welfare of a member. Examples include, but are not limited to, the following:

   a. Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services). Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member.

   b. Failure to provide medically-necessary Medicare or Medicaid covered services to members.

   c. Failure to process prior authorization requests within the prescribed time frames.

   d. Repeated failure to comply with an open remediation plan or CAP or a CAP closed in the last twelve months.

   e. The imposition of premiums or charges on members in excess of the premiums or charges permitted under the MyCare Ohio demonstration project.

   f. Misrepresentation or falsification of information the MCOP furnishes to ODM.

   g. Misrepresentation or falsification of information the MCOP furnishes to a member, potential member, or health care provider.

   h. Failure to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.

   i. Violation of a care management process, including HCBS 1915(c) waiver operations, as specified in Section 2.5.3 of the Three-Way or Appendix K of this Agreement.

3. **Progressive Sanctions Based on Accumulated Points.** Progressive sanctions will be based on the number of points accumulated at the time of the most recent incident. A CAP or other sanction may be imposed in addition to the financial sanctions listed below. The designated financial sanction amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	CAP + No financial sanction
16-25 Points	CAP + $5,000 financial sanction
26-50 Points	CAP + $10,000 financial sanction
51-70 Points	CAP + $20,000 financial sanction
71-100 Points	CAP + $30,000 financial sanction
100+ Points	Proposed Provider Agreement Termination

ii. **Specific Pre-Determined Sanctions.**

1. **Adequate network-minimum provider panel requirements.** Any deficiencies in the MCOP's provider network specified in this Agreement or the Three-Way may result in the assessment of a $1,000 nonrefundable financial sanction for each category (dental, vision, waiver providers etc.) and for each county/zip code. Compliance will be assessed at least quarterly.

   ODM may assess additional sanctions (e.g. CAPs, points, financial sanctions) if (1) the MCOP violates any other provider panel requirements contained within either the Three-Way or this Agreement or (2) the MCOP's member has experienced problems in accessing necessary services because of noncompliance by a provider within the MCOP's panel.

2. **Noncompliance with MyCare Waiver Standards.** ODM may assess a sanction for noncompliance with the HCBS Waiver performance standard specified in Appendix M for each measurement period the MCOP is determined to be noncompliant. Waiver performance measures for which the MCOPs, collectively, do not meet 86%, any MCOP that falls below 86% within that measure is subject to a Corrective Action Plan (CAP).

3. **Late Submissions.**

   a. **Submission of data and documentation to ODM.** All submissions, data, and documentation submitted by the MCOP shall be received by ODM within the specified deadline and shall represent the MCOP in an honest and forthright manner. If the MCOP fails to provide ODM with

any required submission, data or documentation, (with the exception of incident management documentation referenced in this appendix) ODM may assess a nonrefundable financial sanction of $100 per calendar day, unless the MCOP requests and is granted an extension by ODM. Assessments for late submissions will be done monthly.

b. **Submission of incident management documentation to ODM or the incident management vendor.** If the MCOP fails to provide the requested information to ODM or the incident management vendor, in accordance with the defined ODM "MyCare Ohio Incident Escalation Procedure," ODM may assess a nonrefundable financial sanction of $1,000 per incident record, per calendar day until the requested information is provided.

c. **Extension requests.** With the exception of incident management documentation, if the MCOP is unable to meet a program deadline or data/documentation submission deadline, the MCOP shall submit a written request to its Contract Administrator for an extension of the deadline, as soon as possible, but no later than 3 PM, EST, on the date of the deadline in question. Requests for extensions should only be submitted where unforeseeable circumstances have made it impossible for the MCOP to meet a deadline stipulated by ODM and will not be approved for incident management documentation. All such requests will be evaluated upon this standard. ODM may assess a compliance action against an entity, unless written approval for an extension of the deadline has been granted.

3. **Noncompliance with Claims Adjudication Requirements.** If ODM finds the MCOP 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 MCOP with a financial sanction of $20,000 per calendar day for the period of noncompliance. Additionally, the MCOP may be assessed 5 points per incident of noncompliance.

4. **Noncompliance with Financial Performance Measures and/or the Submission of Financial Statements.** If the MCOP fails to meet any financial performance measure set forth in Sections 2.13 or 4.2.6 of the Three-Way or fails to submit to the Ohio Department of Insurance (ODI) financial statements by the due date set by ODI, then ODM may impose upon the MCOP a CAP, or a freeze on the enrollment of new members, or both. The MCOP shall submit financial statements to ODM by ODI's originally specified due date unless ODM grants an extension to the MCOP in writing.

5. **Noncompliance with Reinsurance Requirements.** If ODM determines (1) the MCOP has failed to maintain reinsurance coverage as set forth in 2.13.4. of the Three-Way, (2) the MCOP's deductible exceeds $100,000 without approval from ODM, or (3) the MCOP'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 MCOP to pay a financial sanction to ODM. The amount of the sanction will be the lesser of (1) 10% of the difference between the estimated amount of what the MCOP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCOP actually paid while it was out of compliance or (2) $50,000.

If ODM determines the MCOP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, ODM may subject the MCOP to a CAP.

6. **Noncompliance with Prompt Payment.** ODM may impose progressive sanctions on the MCOP that does not comply with the prompt pay requirements as specified in 42 CFR 447.46 and Section 5.1.9 of the Three-Way.

    a. The first instance of noncompliance during a rolling 12-month period for each claim type listed in Section 5.1.9 of the Three-Way: ODM may assess a refundable financial sanction equal to .04% of the amount calculated in accordance with this appendix. The refundable financial sanction amount will be returned to the MCOP if ODM determines the MCOP is in full compliance with the prompt pay standards within the five consecutive reporting periods following the report period for which the refundable financial sanction was issued.

    b. The second instance of noncompliance during a rolling 12-month period for each claim type listed in Section 5.1.9 of the Three-Way: ODM may assess a nonrefundable financial sanction equal to .08% of the amount calculated in accordance with this appendix.

    c. Subsequent violations during a rolling 12-month period may result in an enrollment freeze of not less than three months duration or until the MCOP has come back into compliance.

7. **Noncompliance with claims payment systemic errors** (CPSEs)**.** ODM may impose financial and progressive sanctions on the MCOP for not complying with claims payment systemic error(s) policies and corrective activities as specified in Appendix C.

    a. ODM may assess a $5,000 non-refundable sanction for failure to identify CPSEs based on the ODM approved process and for failure to:

        i. Meet the dates identified in the monthly report to ODM;

        ii. Re-adjudicate all impacted claims within required time frames.

b. ODM may assess a non-refundable sanction of $25,000 per calendar day that the MCOP is out of compliance.

8. **Noncompliance with Clinical Laboratory Improvement Amendments (CLIA).** If the MCOP fails to comply with CLIA requirements as specified by ODM, then ODM may impose a nonrefundable financial sanction in the amount of a $1,000 for each documented violation.

9. **Noncompliance with Abortion and Sterilization Hysterectomy Requirements.** If the MCOP fails to comply with abortion and sterilization requirements as specified by ODM, then ODM may impose a nonrefundable financial sanction in the amount of $2,000 for each documented violation. Additionally, the MCOP shall take all appropriate action to correct each violation documented by ODM.

10. **Refusal to Comply with Program Requirements.** If ODM has instructed the MCOP it shall comply with a specific program requirement and the MCOP refuses, such refusal constitutes documentation that the MCOP is no longer operating in the best interests of the MCOP's members or the state of Ohio, and ODM may move to terminate or non-renew the MCOP's provider agreement.

11. **Data Reporting Requirements and Data Quality Measures.** ODM reserves the right to withhold an assessment of noncompliance under this appendix due to unforeseeable circumstances.

    a. **Data Reporting Requirements**

        i. **Annual Submission of MCOP Self-Reported, Audited HEDIS Data.** Performance is monitored annually. If the MCOP fails to submit its self-reported, audited HEDIS data as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the self-reported, audited HEDIS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of this Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of this Agreement for the corresponding contract period.

        ii. **Annual Submission of Final HEDIS Audit Report (FAR).** Performance is monitored annually. If the MCOP fails to submit its FAR as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the self-reported, audited HEDIS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of this Agreement for the corresponding contract period. In addition, the MCOP will be

disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of this Agreement for the corresponding contract period.

ODM will review the MCOP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. The MCOP may be required to submit to ODM requested documentation to account for an NR audit designation. Based on its review of the MCOP's FAR and any NR audit designations assigned, ODM may impose corrective action (such as requiring the MCOP to implement a corrective action plan to resolve data collection and/or reporting issues).

iii. **Data Certification Requirements for HEDIS IDSS Data and HEDIS Audit Report.** Performance is monitored annually. If the MCOP fails to submit a required data certification letter to ODM within the required time frame, CMS or ODM may impose a nonrefundable financial sanction of $100 per calendar day, unless the MCOP requests and is granted an extension by ODM.

iv. **Annual Submission of MCOP Health Outcomes Survey (HOS) Data.** Performance is monitored annually. If the MCOP fails to submit its HOS data to CMS, as specified in *CMS' Reporting Requirements for HEDIS, HOS, and CAHPS Measures,* the MCOP will be considered non- compliant with the standards for all of the HOS performance measures referenced in Appendix M of this Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds, as specified in the Three-Way and in Appendix O of this Provider Agreement for the corresponding contract period.

v. **Annual Submission of MCOP Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Data.** Performance is monitored annually. If the MCOP fails to submit its CAHPS data to CMS, as specified in *CMS' Reporting Requirements for HEDIS, HOS, and CAHPS Measures,* the MCOP will be considered non- compliant with the standards for all of the CAHPS performance measures referenced in Appendix M of this Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds, as specified in the Three-Way and in Appendix O of this Provider Agreement for the corresponding contract period.

vi. **Complete and Accurate Submission of Nursing Facility 100-Day Threshold and Discharge Data.** The nursing facility admission and discharge data set may be subject to an audit or review for completeness and accuracy by ODM, or a vendor contracted by ODM. Any overpayments made by ODM to the MCOP as a result of inaccurate or incomplete nursing facility 100-day threshold or discharge data submitted by the MCOP will result in ODM recouping the overpayment(s).

b. **Data Quality Measures.** The MCOP shall submit to ODM, by the specified deadline and according to specifications set by ODM, all required data files and requested documentation needed to calculate each measure listed below. If the MCOP fails to comply with this requirement for any measure listed below, the MCOP will be considered noncompliant with the standards for that measure. Data quality report periods, measures, standards, and requirements are specified in Appendix L of this Agreement and *ODM Measures for the MyCare Ohio Encounter Data Quality Measures*.

Sanctions for noncompliance are assessed for each MCOP as described for each measure.

i. **Encounter Data Volume.** Performance is monitored once every quarter for the entire measurement period for each of the following populations and service combinations: 1) Medicaid services for all MyCare Ohio members; and 2) Medicare services for dual benefit members. Sanctions for noncompliance will be assessed separately, by population and service combination. If the standard is not met for every Medicaid and Medicare service category in all quarters of the measurement period, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a financial sanction of two percent of the amount calculated in accordance with this appendix. If the MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A financial sanction issued under this section will be returned

to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

ii. **Rejected Encounters.** Performance is monitored once every quarter for Measure 1 and once every month for Measure 2 in Appendix L of this Agreement. 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 MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCOP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a financial sanction of two percent of the amount calculated in accordance with this appendix. If the MCOP 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 the MCOP with less than 1,000 members.

A financial sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

iii. **Acceptance Rate.** Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months. If the standard is not met for every file type, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCOP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a financial sanction of two percent of the amount calculated in accordance with this appendix. If the MCOP 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 an MCOP with less than 1,000 members.

A financial sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

iv. **Encounter Data Accuracy Measure.** The first time the MCOP is determined to be noncompliant with the standard for either level 1 or level 2 for this measure, the MCOP shall implement a CAP which identifies interventions and a timeline for resolving data quality issues related to payments. Additional reports to ODM addressing targeted areas of deficiencies and progress implementing data quality improvement activities may be required. Upon all subsequent measurements of performance, if the MCOP is again determined to be noncompliant with the standard for either level 1 or level 2 for this measure, ODM may impose a financial sanction of one percent of the amount calculated in accordance with this appendix.

A financial sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued.

v. **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 MCOP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a financial sanction of two percent of the amount calculated in accordance with this appendix. If the MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A financial sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

vi. **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 MCOP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a financial sanction of two percent of the amount calculated in accordance with this appendix. If the MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A financial sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze

issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

vii. Encounter Submissions per ODM's Methodology for MyCare Ohio Encounter Data Quality Measures document is monitored once every month. If the standard is not met for the measurement period, the MCOP will be noncompliant for the measurement period.

ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time the MCOP is determined to be noncompliant with the standard for this measure, ODM may impose a financial sanction of one percent of the amount calculated in accordance with this appendix. If the MCOP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a financial sanction of two percent of the amount calculated in accordance with this appendix.

A financial sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued.

viii. **Timeliness of Encounter Data Submission.** Performance is monitored once every month. If the standard is not met for the measurement period, the MCOP will be noncompliant for the measurement period.

ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may impose a financial sanction of one percent of the amount calculated in accordance with this appendix. If the MCOP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a financial sanction of two percent of the amount calculated in accordance with this appendix.

A financial sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued.

12. **Quality Measures.** The MCOP shall submit to ODM, by the specified deadline and according to ODM specifications, all required data files and requested documentation needed to assess the quality measures specified any quality measure listed in Appendix M of this Agreement, the MCOP will be considered noncompliant with the standards for that measure.

    ODM reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

    For each measure and population (i.e., dual benefit members and Medicaid-only members) as specified in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of this Agreement, one rate is calculated. Each rate per specified population has an associated Minimum Performance Standard. When the MCOP fails to meet a Minimum Performance Standard listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of this Agreement, for a measure and specified population for which noncompliance sanctions are applicable, the MCOP will 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 and population. For example, two rates, corresponding to the dual benefit member population and Medicaid-only member population, are calculated for the *Long-Term Care Overall Balance* measure. An MCOP failing to meet the standard established for the dual benefit member population rate in three consecutive measurement periods would be subject to progressive sanctions. However, an MCOP failing to meet the standard established for the dual benefit member population rate in one measurement period and the Medicaid-only member population in the next would not be subject to progressive sanctions, as these only apply to the standard established for the same rate and population.

    For the standard established for each rate and specified population listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of this Agreement, for measures for which noncompliance sanctions are applicable, the MCOP may be assessed sanctions for instances of noncompliance as follows:

    a. The first instance, or subsequent but nonconsecutive instance, of noncompliance: ODM may impose a financial sanction in the amount of one quarter of one percent of the amount calculated in accordance with this appendix for the twelve months prior to the month in which the compliance action is issued to the MCOP. If the MCOP is determined to be in full compliance with this program requirement within the following five consecutive report periods, the financial sanction will be returned.

b. The second consecutive instance of noncompliance: ODM may impose a financial sanction in the amount of one quarter of one percent of the amount calculated in accordance with this appendix for the twelve months prior to the month in which the compliance action is issued to the MCOP. This financial sanction non-refundable.

c. The third consecutive, and any additional consecutive, instance of noncompliance: ODM may impose a financial sanction in the amount of one half of one percent of the amount calculated in accordance with this appendix for the twelve months prior to the month in which the compliance action is issued to the MCOP. The financial sanction is nonrefundable.

d. In addition, if ODM determines the MCOP is noncompliant with greater than 50% of the applicable quality standards listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of this Agreement, for which noncompliance sanctions are applicable, for two consecutive contract years, ODM may terminate this Agreement.

13. **Quality Care.** ODM reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

a. **Administrative Compliance Assessment.** Compliance with administrative standards is performed by the external quality review organization, as specified by ODM. For each documented instance of noncompliance with an administrative standard, the MCOP may be required to submit a CAP as specified by ODM to remedy the identified deficiency.

b. **Care Management Data Submission.** The MCOP shall submit to ODM all required care management data as specified in ODM's *MyCare Ohio Care Management Data Submission Specifications*. If the MCOP fails to comply with the timely submission requirement, then ODM may impose a nonrefundable financial sanction of $100 per calendar day, unless the MCOP requests and is granted an extension by ODM.

c. **Care Management Data Certification Requirements.** If the MCOP fails to submit a required Care Management data certification letter to ODM within the required time frame, ODM may impose a nonrefundable financial sanction of $100 per calendar day, unless the MCOP requests and is granted an extension by ODM.

d. **HCBS Waiver Operational Reporting Requirements.** The MCOP shall submit to ODM all required HCBS waiver operational reporting requirements as specified by ODM or CMS or both. If the MCOP fails to

submit a required reporting to ODM within the required time frame, CMS or ODM may impose a nonrefundable financial sanction of $100 per calendar day, unless the MCOP requests and is granted an extension by ODM.

e. **Care Management Reviews.** ODM may assess sanctions for noncompliance with the care management review performance standards specified in Appendix K For each measurement period the MCOP is determined to be noncompliant, ODM may impose a nonrefundable financial sanction of one quarter of one percent of the amount calculated in accordance with this appendix.

f. **Member Safeguards.** In addition to points that may be assessed pursuant to this appendix, ODM may assess a non-refundable financial sanction of $50,000 (per case) for noncompliance, whether a single instance or systematic, that places a member at risk for a negative health outcome or jeopardizes the member's health and safety. This financial sanction may be in accordance with ODM's Health, Safety, Welfare Improvement Process for Medicaid Managed Care Consumers.

g. **Maintenance of National Committee for Quality Assurance Health Plan Accreditation.** For the standard established in Section 2.2.4 of the Three-Way, ODM may assess the following sanctions for noncompliance:

i. If the MCOP receives a provisional accreditation status, the MCOP 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 Agreement and may terminate the Agreement with the MCOP.

ii. If the MCOP receives a denied accreditation status, ODM will consider this a material breach of the Agreement and may terminate the Agreement with the MCOP.

14. **Noncompliance with Provision of Transportation Services.** If the MCOP fails to comply with the transportation requirements specified in Appendix C of this Agreement, or if the MCOP fails to transport a member to a pre-scheduled appointment on time, which results in a missed appointment, when providing Medicaid-covered transportation services and when members shall travel more than 30 miles to receive services, ODM may impose a nonrefundable financial sanction in the amount of $1,000 for each violation. ODM may assess additional sanctions (e.g., CAPs, points, financial sanctions) as provided for in this appendix for any violation of the Medicaid-covered transportation services and applicable requirements.

15. **Noncompliance with HealthTrack complaints.** If the MCOP fails to comply with the HealthTrack complaint requirements as specified in Appendix C of this Agreement, ODM may require the MCOP to complete a CAP and specify the date by which compliance shall be demonstrated.

iii. **Financial Sanctions.** Refundable or nonrefundable financial sanctions may be assessed separately or in combination with other sanctions/remedial actions. The total financial sanctions assessed in any one month will not exceed 15% of one month's payments from ODM to the MCOP. Unless otherwise stated, all financial sanctions are nonrefundable.

1. Refundable and nonrefundable financial sanctions/assurances assessed against the MCOP shall be directly deduced from the net premium amount paid to the MCOP. ODM will specify on the invoice the date the funds will be deducted.

2. If an Electronic Funds Transfer (EFT) is requested by ODM, the refundable and nonrefundable financial sanction/assurance shall be paid by the MCOP to ODM within 30 calendar days of receipt of the invoice by the MCOP, or as otherwise directed by ODM in writing. In addition, per ORC Section 131.02, payments owed to the State not received within 45 calendar days will be certified to the Attorney General's (AG's) office. The AG's Office will assess the appropriate collection fee for MCOP payments certified to the AG's Office.

3. For financial sanctions calculated in accordance with this section, ODM will use the MCOP's average monthly net premium amount, disregarding refundable and nonrefundable financial sanctions, for the twelve months prior to the month in which the compliance action is issued to the MCOP.

4. Unless otherwise specified, any monies collected through the imposition of a refundable financial sanction will be returned to the MCOP (minus any applicable collection fees owed to the AG's Office if the MCOP has been delinquent in submitting payment) after it has demonstrated full compliance with the particular program requirement, as determined by ODM. Refunds will be added to the net premium amount paid to the MCOP.

5. The MCOP is required to submit a written request for refund to ODM at the time it believes is appropriate before a refund of monies will be considered.

6. Refundable financial sanctions issued under sections 2.b.ii.10, 2.b.ii.11, and 2.b.ii.12 of this appendix will be returned to the MCOP in the event ODM replaces or eliminates the sanction's applicable measures from the Agreement for the measurement period immediately following the measurement period for which the sanction was assessed.

iv. **New Enrollment Freezes.** Notwithstanding any other sanction or point assessment ODM may impose on the MCOP under this Agreement, ODM may prohibit the MCOP from receiving new enrollment through consumer initiated selection or the assignment

process if any of the following occur: (1) the MCOP has accumulated a total of 51 or more points during a rolling 12-month period; (2) the MCOP has failed to fully implement a plan of correction within the designated time frame; (3) circumstances exist that potentially jeopardize the MCOP's members' access to care, as solely determined by ODM; or (4) the MCOP is found to have a pattern of repeated or ongoing noncompliance, as solely determined by ODM. Examples of circumstances ODM may consider as jeopardizing member access to care include, but are not limited to, the following:

1. The MCOP has been found by ODM to be noncompliant with the prompt payment or the non-contracting provider payment requirements;

2. The MCOP has been found by ODM to be noncompliant with the provider panel requirements specified in Appendix H of this Agreement;

3. The MCOP has refused to comply with a program requirement after ODM has directed the MCOP to comply with the specific program requirement;

4. The MCOP has received notice of proposed or implemented adverse action by the ODI; or

5. The MCOP has failed to provide adequate provider or administrative capacity.

Payments provided for under this Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.726.

New Member Enrollment freezes issued under this appendix may be lifted in the event ODM replaces or eliminates the sanction's applicable measure(s) from this Agreement for the measurement period immediately following the measurement period for which the sanction was assessed.

Unless otherwise specified, new enrollment freezes issued under this appendix may be lifted after the MCOP is determined to be in full compliance with the applicable program requirement, and the violations or deficiencies are resolved to the satisfaction of ODM.

v. **Reduction of Assignments.** ODM has discretion over how member auto-assignments are made. ODM may reduce the number of assignments the MCOP receives to ensure program stability within a region, or upon a determination that the MCOP lacks sufficient capacity to meet the needs of the increased enrollment volume. ODM may determine the MCOP has demonstrated a lack of sufficient capacity under circumstances that include, but are not limited to when the MCOP has failed to:

1. Maintain an adequate provider network;

2. Provide new member materials by the member's effective date;

3. Meet the minimum call center requirements;

4. Meet the minimum performance standards for members with special health care needs; or

5. Provide complete and accurate data files regarding appeals or grievances, or its care management program.

vi. **Death or Injury to Member.** ODM may immediately terminate or suspend this Agreement if the MCOP's failure to perform, or properly perform, any of the requirements in this Agreement results in the death of or serious injury to, the MCOP's member, as determined by ODM.

3. **Request for Reconsiderations.** Unless otherwise specified below, the MCOP 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, financial sanctions, and member enrollment freezes.

   a. The MCOP may not seek reconsideration of:

      i. An action by ODM that results in changes to the auto-assignment of members.

      ii. The imposition of directed CAPs as defined in II of this appendix.

   b. The MCOP shall submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:

      i. The MCOP shall submit a request for reconsideration either by email to the designated Contract Administrator (CA), or by overnight mail to ODM's Office of Managed Care (OMC). The request for reconsideration shall be received by ODM no later than the tenth business day after the date that the MCOP 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 MCOP.

      ii. A request for reconsideration shall explain in detail why the specified sanction should not be imposed. At a minimum, the reconsideration shall include: the proposed action being contested; the basis for requesting reconsideration; and any supporting documentation. In considering the MCOP's request for reconsideration, ODM will review only the written material submitted by the MCOP.

      iii. ODM will take reasonable steps to make a final decision, or request additional information, within ten business days after receiving the request for reconsideration. If ODM requires additional time, the MCOP will be notified in writing.

iv. If ODM approves a reconsideration request, in whole, the associated sanctions or remedial actions will be rescinded. The MCOP will not be required to submit a CAP.

v. If ODM approves, in part, the MCOP's reconsideration request, the sanction, remedial action, and/or the points associated with the incident may be rescinded or reduced, at the discretion of ODM. The MCOP may still be required to submit a CAP if ODM, in its discretion, believes a CAP is still warranted under the circumstances.

vi. If ODM denies the MCOP's reconsideration request, any CAP, sanction, remedial action, and/or points outlined in the original notice of noncompliance will be assessed.

APPENDIX O

QUALITY WITHHOLDS

1. **Dual Benefit Members Quality Withhold Policies and Measures.** Section 4 of the Three-Way specifies the quality withhold policies and measures for the dual benefit members (opt-in population). For the dual benefit members (opt-in population), the quality withhold methodology is specified in *CMS' Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes (DY 2 through 5)*.

2. **Medicaid-Only Members Quality Withhold Policies and Measures.** For each year of the demonstration, ODM will withhold a percentage of the MCOP's Medicaid-only (opt-out population) capitation rate. The quality withhold is two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Years 3 through 6. For Demonstration Years 2 through 6, the percent of Medicaid-only withheld amounts repaid to the MCOP will be equal to the percent of withhold the MCOP receives for the dual-benefit (opt-in) members as determined in accordance with the *'CMS' Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes' for the applicable demonstration year.*

   In recognition of requirements in this Agreement, the Health Insuring Corporation (HIC) Franchise Fee component of the MCOP capitation rates will be automatically assigned a payout award of 100%.

The sanctions for non-compliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX P

TERMINATION/NONRENEWAL

1. **Plan-Initiated Terminations/Nonrenewal.** If a MyCare Ohio Plan (MCOP) provides notice of the termination/nonrenewal of this Agreement to ODM, pursuant to Article VIII of this Agreement or Section 5.5 of the Three-Way, the MCOP will be required to comply with the following:

    a. **Fulfill Existing Duties and Obligations.** The MCOP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-58 and any agreements related to the provision of services for the Medicaid population during periods of time when the MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP 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 MCOP for the Agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCOP for the MCOP's Agreement time periods.

    b. **Refundable Monetary Assurance.** The MCOP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCOP 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 Agreement. The monetary assurance shall be in an amount of either $50,000 or 5% of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

    The MCOP shall remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP shall contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP shall send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

    If the monetary assurance is not received as specified above, ODM may withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, the MCOP 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 Agreement, the monetary assurance will not be refunded to the MCOP.

    c. **Withhold Amount**. Any withhold amount in the managed care program performance payment fund will be retained by ODM.

    d. **Final Accounting of Amounts Outstanding.** The MCOP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after the termination/nonrenewal date. Failure by the MCOP to submit a list of outstanding items will be

deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

e. **Financial Sanctions.** All previously collected refundable financial sanctions shall be retained by ODM.

f. **Data Files**. In order to assist members with continuity of care, the terminating MCOP shall create data files to be shared with each newly enrolling MCOP. The data files shall 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, pregnant members, and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The terminating MCOP will be responsible for ensuring the accuracy and data quality of the files.

g. **Notification.**

i. **Provider Notification.** The MCOP shall notify contracted providers at least 55 calendar days prior to the effective date of termination. The provider notification shall be approved by ODM prior to distribution.

ii. **Member Notification.** Unless otherwise notified by ODM, the MCOP shall notify its members regarding its provider agreement termination at least 45 calendar days in advance of the effective date of termination. The member notification shall be approved by ODM prior to distribution.

iii. **Prior Authorization Re-Direction Notification.** The MCOP shall create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCOP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCOP shall utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCOP membership.

2. **ODM-Initiated Terminations For Cause.**

a. If ODM initiates the proposed termination, nonrenewal or amendment of this Agreement pursuant to OAC rules 5160-58-01.1 and 5160-26-10 by issuing a proposed adjudication order pursuant to O.R.C. 5164.38, and the MCOP submits a valid appeal of that proposed action pursuant to O.R.C. Chapter 119, the MCOP's Agreement will be extended through the issuance of an adjudication order in the MCOP's appeal under ORC Chapter 119.

During this time, the MCOP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation under Appendix N of this Agreement.

If the MCOP exceeds 69 points, each subsequent point accrual will result in a $15,000 nonrefundable financial sanction.

Pursuant to OAC rules 5160-58-01.1 and 5160-26-10, if ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODM may notify the MCOP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCOP 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 MCOP's members. The appeal process for reconsideration of the proposed termination of members is as follows:

i. All notifications of such a proposed MCOP membership termination will be made by ODM via certified or overnight mail to the identified MCOP contact.

ii. An MCOP notified by ODM of such a proposed MCOP membership termination will have three business days from the date of receipt to request reconsideration.

iii. All reconsideration requests shall be submitted by either facsimile transmission or overnight mail to the Director, Ohio Department of Medicaid, and received by 3PM Eastern Time on the third business day following receipt of the ODM notification of termination. The address and fax number to be used in making these requests will be specified in the ODM notification of termination document.

iv. The MCOP will be responsible for verifying timely receipt of all reconsideration requests. All requests shall explain in detail why the proposed MCOP membership termination is not justified. The MCOP's justification for reconsideration will be limited to a review of the written material submitted by the MCOP.

v. A final decision or request for additional information will be made by the Director within three business days of receipt of the request for reconsideration. Should the Director require additional time in rendering the final reconsideration decision, the MCOP will be notified of such in writing.

vi. The proposed MCOP membership termination will not occur while an appeal is under review and pending the Director's decision. If the Director denies the appeal, the MCOP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODM determines it would be in the best interest of the members.

b. **Fulfill Existing Duties and Obligations.** The MCOP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-58 and this Agreement related to the provision of services for the Medicaid population during periods of time when MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and member complaints for the Medicaid population served by the MCOP for the Agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCOP

for the Agreement time periods.

c. **Refundable Monetary Assurance.** The MCOP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter, and cost report data related to time periods through the final date of service under this Agreement. The monetary assurance shall be in an amount of either $50,000 or 5% of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

   The MCOP shall remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP shall contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP shall send copies of the EFT bank confirmations and copies of the invoices to its Contract Administrator.

   If the monetary assurance is not received as specified above, ODM will withhold the MCOP's next month's capitation payment until such time ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, the MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter, and cost report data related to time periods through the final date of service under this Agreement, the monetary assurance will not be refunded to the MCOP.

d. **Withhold Amount**. Any withhold amount in the managed care program performance payment fund will be retained by ODM.

e. **Financial Sanctions**. All previously collected refundable financial sanctions shall be retained by ODM.

f. **Final Accounting of Amounts Outstanding**. The MCOP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after the termination/nonrenewal date. Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. 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 terminating MCOP shall create data files to be shared with each newly enrolling MCOP. The data files shall 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, pregnant members, and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The terminating MCOP will be responsible for ensuring the accuracy and data quality of the files.

h. **Notification.**

i. **Provider Notification.** The MCOP shall notify contracted providers at least 55 calendar days prior to the effective date of termination. The provider notification shall be approved by ODM prior to distribution.

ii. **Prior Authorization Re-Direction Notification.** The MCOP shall create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCOP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCOP shall utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCOP membership.

3. **Termination or Modification of this Agreement Due to Lack of Funding.** Should this Agreement terminate or be modified due to a lack of available funding as set forth in the Baseline of this Agreement, the MCOP has no right to appeal the selection process under ORC Chapter 119 pursuant to ORC Section 5164.38 and will be required to comply with the following:

a. **Fulfill Existing Duties and Obligations.** The MCOP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-58 and this Agreement related to the provision of services for the Medicaid populations during periods of time when the MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP 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 MCOP for the Agreement time periods, and provision of data to support audits related to the Medicaid populations served by the MCOP for the Agreement time periods.

b. **Refundable Monetary Assurance.** The MCOP will be required to submit a refundable monetary assurance should the Agreement terminate. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter, and cost report data related to time periods through the final date of service under this Agreement. The monetary assurance shall be in an amount of either $50,000 or 5% of the capitation amount paid by ODM in the month the termination notice is issued, whichever is greater.

The MCOP shall remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP shall contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP shall send copies of the EFT bank confirmations and copies of the invoices to its Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, financial sanctions or sanctions, encounter, and cost report data related to time periods through the final date of service under this Agreement, the monetary assurance will not be refunded to the MCOP.

c. **Withhold Amount.** Any withhold amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.

d. **Financial Sanctions.** Previously collected refundable financial sanctions directly and solely related to the termination or modification of this Agreement shall be returned to the MCOP.

e. **Final Accounting of Amounts Outstanding.** The MCOP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after a termination/nonrenewal date of this Agreement. Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. 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 MCOP shall create data files if requested by ODM. The data files shall 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, pregnant members, and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The MCOP will be responsible for ensuring the accuracy and data quality of the files.

g. **Provider Notification.** The MCOP shall notify contracted providers within 30 calendar days of notice from ODM of the effective date of termination or modification of this Agreement. The provider notification shall be approved by ODM prior to distribution.

The sanctions for non-compliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX Q

PAYMENT REFORM

The Ohio Department of Medicaid (ODM) is committed to reforming the health care delivery system by designing and implementing systems of payment that signal powerful expectations for improved health care delivery.

1. The MCOP shall support and advance initiatives where payment for MyCare Ohio is increasingly designed to improve and reflect effectiveness and efficiency with which providers deliver care. The MCOP shall ensure that members are engaged in managing their health, selecting their providers, and maintaining sensitivity to the cost and quality of services they seek. The MCOP shall achieve progress in the following areas:

    a. **Value-Oriented Payment.** The MCOP shall design and implement payment methodologies with its network providers designed to cut waste, reflect value, or both. For the purposes of this Agreement, payments that cut waste are those that by their design reduce unnecessary payment and unnecessary care (e.g. nursing facility stays). 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.** The MCOP 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, the MCOP shall establish programs to engage MCOP members to make informed choices and to select evidence-based, cost-effective care.

    c. **Transparency.** The MCOP 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 MCOP shall contribute to the program design, provide data as specified by ODM, and publish results in accordance with standards established by the Department.

2. The MCOP shall establish value-based contracts with nursing facilities. Examples of what a MCOP should focus on in designing payment strategies with nursing facilities include hospital readmission; re-balancing and approach to shifting members from nursing facilities to home- and community-based services; and episodes of care).

    The MCOP shall establish value-based contracts that impact at least 10 nursing facilities. Payments made by the MCOP to nursing facilities under these value-based contracts shall be in addition to payments made in accordance with ORC 5165.15 through 5165.49. In addition, the MCOP shall submit a quarterly report as specified by ODM that addresses progress towards meeting these obligations.

    Examples of strategies include the following:

a. Pay providers differentially according to performance (and reinforce with benefit design);

b. Design approaches to payment that cut waste while not diminishing quality, including reducing unwarranted payment variation;

c. Design payments to encourage adherence to clinical guidelines. For example, at a minimum, the MCOP shall address policies to discourage elective deliveries before 39 weeks;

d. Develop 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).

3. **Reporting**. The MCOP shall submit a quarterly progress report as specified by ODM that addresses progress towards meeting the obligations as outlined above. ODM will provide a report template. The report elements shall include:

a. A description of the value-based purchasing strategies;

b. Type of provider(s);

c. Objective of each value-based purchasing strategy and progress in meeting each objective;

d. Type of value-based arrangement (e.g. upside risk or downside risk);

e. Sum of total gross payments to waiver and/or nursing facility providers, if applicable;

f. Sum of total net payments to waiver and/or nursing facility providers, if applicable;

g. Number of Medicaid per diem related days paid and revenue center codes for nursing facility providers, if applicable; and

h. Unique count of members.

The sanctions for non-compliance with requirements in this appendix are listed in Appendix N of this Agreement.