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

This Provider Agreement (hereinafter "Agreement") is entered into this first day of July, 2020, at Columbus, Franklin County, Ohio, between the State of Ohio, the Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal office is located in the City of Columbus, County of Franklin, State of Ohio, and _____, Managed Care Plan (hereinafter referred to as the MCP), an Ohio corporation, whose principal office is located in the city of _____, County of _____, State of Ohio.

The MCP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and agrees to operate as prescribed by Chapter 5167 of the ORC, Chapter 5160-26 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time. Upon request, the MCP shall submit to ODM any data submitted to ODI to establish the MCP has adequate provisions against the risk of insolvency as required under 42 CFR (Code of Federal Regulations) 438.116 and to ensure that neither members nor ODM shall be liable for any MCP debts, including those that remain in the event of MCP insolvency or the insolvency of any subcontractors.

The MCP 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 eligible population described in OAC rule 5160-26-02 along with any other Medicaid eligible populations authorized by the Centers for Medicare and Medicaid Services (CMS) and described in Ohio's Medicaid State Plan.

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

This Agreement is a contract between ODM and the undersigned MCP pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCP agrees to provide or arrange for comprehensive Medicaid services through the managed care program as provided in ORC Chapter 5167 and OAC Chapter 5160-26, 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 MCP's representations that it has the necessary expertise and experience to perform its obligations hereunder, and the MCP represents and warrants that it does possess such necessary expertise and experience.

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

C. The MCP 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 MCP concerning the performance of the services described in this Agreement. Upon such notice and within the designated time frame after receipt of instructions, the MCP shall comply with such instructions and fulfill such requests to the satisfaction of the department. It is expressly understood by the parties that these instructions and requests are for the sole purpose of performing the specific tasks requested to ensure satisfactory completion of the services described in this 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, 2021, 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 compute capitation rates on an actuarially sound basis in accordance with 42 CFR 438.5. The capitation rates do not include any amount for risks assumed under any other existing agreement or contract, or any previous agreement or contract. ODM will review the capitation rates at least annually and the rates may be modified based on existing or anticipated actuarial factors and experience.

B. The amounts paid by ODM in accordance with this Agreement represent a full-risk arrangement and the total obligation of ODM to the MCP for the costs of medical care and services provided.

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

ARTICLE IV - RELATIONSHIP OF PARTIES

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

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

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

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

ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS

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

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

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

D. Any such person who acquires an incompatible, compromising or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, shall immediately disclose his or her interest to ODM in writing. Thereafter, he or she shall not participate in any action affecting the services under this 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 MCP shall promise or give to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. The MCP, along with its officers, members, and employees, understand and agree to take no action, or cause ODM or its employees to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws including without limitation those provisions found in ORC Chapter 102 and 2921.

F. The MCP hereby covenants that the MCP, its officers, members, and employees are in compliance with ORC section 102.04, and that if MCP 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 MCP agrees that in the performance of this Agreement or in the hiring of any employees for the performance of services under this Agreement, the MCP 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 MCP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the 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 5160-26, the MCP agrees to hold all subcontractors and persons acting on behalf of the MCP 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 MCP agrees that all records, documents, writings, or other information produced by the MCP under this Agreement and all records, documents, writings, or other information used by the MCP in the performance of this Agreement shall be treated in accordance with OAC rule 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 MCP shall maintain an appropriate record system for services provided to members. The MCP 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 MCP acknowledges that these records, including those of any subcontractors and other delegated entities, may be a part of any audit conducted by the Auditor of the State of Ohio per ORC Chapter 117.

B. All information provided by the MCP 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 MCP at a disadvantage in the market place and trade of which the MCP is a part, and (b) meets the definition of “trade secret” as defined in ORC section 1333.61(D). The MCP agrees to expressly indicate by marking the top or bottom of each individual record containing information the MCP deems proprietary, 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 MCP as proprietary shall not be held confidential and the MCP waives any claim that the record is proprietary. Upon request from ODM, the MCP agrees to promptly notify ODM in writing of the nature of the proprietary information including all reasonable evidence regarding the nature of the proprietary information in records submitted to ODM, and specifically identify the proprietary information contained in each individual record.

ODM will not share or otherwise disclose proprietary information received from the MCP to any third party without the express written authorization of the MCP, 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 MCP 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 MCP proprietary information, ODM shall reasonably promptly notify the MCP and shall do so before any disclosure. If the MCP 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 MCP agrees to provide for the legal defense of all such proprietary information. The MCP 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 MCP or by ODM. If the MCP fails to promptly notify ODM in writing that the MCP 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 MCP 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 MCP 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 MCP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Agreement. The MCP agrees to be bound by the same standards of confidentiality that apply to the employees of ODM and the State of Ohio, including without limitation the confidentiality requirements found in 42 CFR Part 431 Subpart F and ORC 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 MCP for services under this Agreement. The MCP 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 Part 160 and 164.

D. The MCP 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 MCP.

E. All records relating to performance under or pertaining to this Agreement will be retained by the MCP 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 (3) 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 MCP agrees to pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.

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

G. The MCP shall promptly notify ODM of any legal matters and administrative proceedings including, but not limited to, litigation and arbitration, which involve or otherwise pertain to the activities performed pursuant to this Agreement and any third party. In the event that the MCP possesses or has access to information and/or documentation needed by ODM with regard to the above, the MCP agrees to cooperate with ODM in gathering and 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, by the ODM or the MCP upon written notice in accordance with the applicable rule(s) of the OAC, with termination to occur at the end of the last day of the termination month.

B. Subsequent to receiving a notice of termination from ODM, the MCP beginning on the effective date of the termination, shall cease provision of services on the terminated activities under this 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 MCP 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 MCP agrees to waive any right to, and shall make no claim for, additional compensation against ODM by reason of such suspension or termination.

D. In the event of termination under this Article, the MCP shall return all records in their native format relating to cost, work performed, supporting documentation for invoices submitted to ODM, and copies of all materials produced under or pertaining to this Agreement.

E. ODM may, in its sole discretion, terminate or fail to renew this Agreement if the MCP or MCP's subcontractors violate or fail to comply with the provisions of this Agreement or other provisions of law or regulation governing the Medicaid program. Where ODM proposes to terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the OAC with respect to ODM's suspension, termination, or refusal to enter into a provider agreement shall apply, including the MCP's right to request an adjudication hearing under ORC Chapter 119. The MCP 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 MCP pursuant to ORC section 5167.10.

F. When initiated by the MCP, termination of or failure to renew the Agreement requires written notice to be received by ODM at least 240 calendar days in advance of the termination or renewal date, provided, however, that termination or non-renewal shall be effective at the end of the last day of a calendar month.

In the event of non-renewal of the Agreement with ODM, if the MCP is unable to provide the required number of days of notice to ODM prior to the date when the Agreement expires, then the Agreement shall be deemed extended to the last day of the month that meets the required number of days from the date of the termination notice, and both parties shall, for that time, continue to fulfill their duties and obligations as set forth herein. If the MCP wishes to terminate or not renew their Agreement for a specific region(s), ODM reserves the right to initiate a procurement process to select additional MCPs to serve Medicaid consumers in that region(s). ODM, at its discretion, may use the MCP's termination or non-renewal of this Agreement as a factor in any future procurement process.

G. The MCP 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, Modified Adjusted Gross Income, 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 writing constitutes the entire Agreement between the parties with respect to all matters herein. This Agreement may be amended only by a writing signed by both parties. Any written amendments to this Agreement shall be prospective in nature.

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

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

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

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

ARTICLE X - LIMITATION OF LIABILITY

A. The MCP agrees to (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 MCP in the fulfillment of this Agreement or arising from this Agreement which are attributable to the MCP's

own actions or omissions, or of those of its trustees, officers, employees, agents, subcontractors, suppliers, third parties utilized by the MCP, or joint ventures. Such claims shall include but are not limited to: any claims 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 MCP shall be responsible for and 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 MCP hereby agrees to be liable for any loss of federal funds suffered by ODM for enrollees resulting from specific, negligent acts or omissions of the MCP or its subcontractors during the term of this Agreement, including but not limited to the nonperformance of the duties and obligations to which the MCP has agreed under this Agreement.

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

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

ARTICLE XI - ASSIGNMENT

A. Medicaid members may not be transferred by one MCP to another entity without the express prior written approval of ODM. Even with ODM’s prior written approval, ODM reserves the right to offer such members the choice of MCPs outside the normal open enrollment process and implement an assignment process as ODM determines is appropriate. 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 MCP to successfully complete a readiness review process before the transfer of members under this Agreement.

B. MCPs 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 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 MCP to successfully complete a readiness review process before the transfer of obligations under this Agreement.

C. The MCP 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 MCP

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

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

C. The MCP certifies that neither the MCP nor any principals of the MCP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal agency. The MCP also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC section 153.02 or ORC section 125.25. The MCP also certifies that the MCP has no employment, consulting, or any other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the MCP's contractual obligation with ODM. This certification is a material representation of fact upon which reliance was placed when this Agreement was entered into. Federal financial participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services. If it is ever determined that the MCP knowingly executed this certification erroneously, then in addition to any other remedies, this 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 MCP certifies that the MCP is not on the most recent list established by the Secretary of State, pursuant to ORC section 121.23, which identifies the MCP as having more than one unfair labor practice contempt of court finding. This certification is a material representation of fact upon which reliance was placed when this Agreement was entered into.

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

F. The MCP certifies and affirms that, as applicable to the MCP, 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 MCP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, the MCP shall return to ODM all monies paid to the MCP under this Agreement. The provisions of this section shall survive the expiration or termination of this Agreement.

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

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

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

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

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

L. The MCP agrees that it is in compliance with the Federal Acquisition Regulation (FAR) for Combatting Trafficking in Persons, 48 CFR 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 5160-26 is hereby incorporated by reference as part of this Agreement having the full force and effect as if specifically restated herein.

B. Appendices A through S and any additional appendices are hereby incorporated by reference as part of this Agreement having the full force and effect as if specifically restated herein. Appendix 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 inconsistency or ambiguity between the provisions of OAC Chapter 5160-26 and this Agreement, the provisions of OAC Chapter 5160-26 shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, as provided in Article IX of this Agreement, in which case such federal or state law shall be determinative of the obligations of the parties. In the event OAC Chapter 5160-26 is silent with respect to any ambiguity or inconsistency, the Agreement (including Appendices) shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the 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.

MCP 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)
Medicaid Managed Care Provider Agreement
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APPENDIX R	PHARMACY SERVICES
APPENDIX S	STATE OF EMERGENCY REQUIREMENTS

APPENDIX A

OAC RULES

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

2. **Distribution List Subscriptions.** The MCP shall subscribe to the appropriate distribution lists for notification of all OAC rule clearances, and final rules published with medical assistance letters (MALs), Medicaid handbook transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. The MCP is solely responsible for submitting its names and email addresses to the appropriate distribution lists and is also responsible for ensuring the validity of any 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

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

   Central/Southeast Region ☒
   Northeast Region ☒
   West Region ☒

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

   The MCP shall serve all counties in any region they agree to serve.

2. **Ohio MCP Regions.** Counties are grouped into three regions as identified below.

Counties in the Central/Southeast Region

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

Counties in the Northeast Region

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

Counties in the West Region

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

APPENDIX C

PLAN RESPONSIBILITIES

The following are Managed Care Plan (MCP) responsibilities not otherwise specifically stated in Ohio Administrative Code (OAC) rule or elsewhere in this Agreement.

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

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

3. The MCP shall designate the following:

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

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

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

    a. All MCP employees are to direct all day-to-day submissions and communications to their ODM-designated Contract Administrator within the Office of Managed Care (OMC) unless otherwise notified by ODM. If the MCP 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 MCP unless ODM has specifically instructed the MCP to contact these entities directly.

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

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

6. The MCP shall have an Ohio Medicaid Managed care program administrative office located in Ohio.

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

8. **Required MCP Staff.** The MCP shall have the key Ohio Medicaid Managed Care program staff identified below based and working in the state of Ohio. Key management and supervisory staff for positions associated with new products and services shall be in place at least 60 calendar days prior to the effective date of the new products and services. Each key staff person identified below may occupy no more than one of the positions listed below, unless the MCP receives prior written approval from ODM stating otherwise. These key staff are:

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

    b. **Medical Director/CMO** who is a physician with a current, unencumbered license through the Ohio State Medical Board. The Medical Director shall have at least three years of training in a medical specialty. The Medical Director shall devote full time (minimum 32 hours weekly) to the MCP's operations to ensure timely medical decisions, including after-hours consultation as needed. The Medical Director shall be actively involved in all major clinical and quality management components of the MCP. At a minimum, the Medical Director shall be responsible for:

        i. Development, implementation, and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the MCP grievance system;

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

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

    c. **Behavioral Health (BH) Administrative Director** who possesses an independent, current, and unrestricted Ohio license to provide BH services in the State of Ohio (MD, DO, RN with Advance Practice Registered Nurse (APRN) licensure, Psychologist, LISW, PCC, IMFT) and has a minimum of five years of experience in the provision and supervision of treatment service for mental illness and substance use disorders. The BH Administrative Director shall demonstrate knowledge and understanding of Ohio's overall BH system which includes mental health, alcohol and drug addiction, and developmental disabilities services. He or she shall be responsible for the daily operational activities of BH services across the full spectrum of care to members, inclusive of mental health and substance abuse services. The primary functions of the BH Administrative Director are:

        i. Ensuring access to BH services including mental health and substance abuse services;

ii. Ensuring systematic screening for BH related disorders by utilizing standardized and/or evidence-based approaches;

iii. Promoting preventive BH strategies;

iv. Identifying and coordinating assistance for identified Beneficiary needs specific to BH;

v. Participating in management and program improvement activities with other key staff (including the BH Clinical Director) for enhanced integration with primary care and coordination of BH services and achievement of outcomes; and

vi. Working with the BH Clinical Director, as needed, in the development and maintenance of programs and systems.

d. **Behavioral Health (BH) Clinical Director** who is a dedicated part-time staff, at a minimum, with continuous engagement to perform the functions of a BH Clinical Director. These personnel must be practicing within the scope of his or her license and must hold a current unrestricted Ohio license as either a Clinical Psychologist, or a Board Certified Psychiatrist, with a minimum of three years professional experience in a clinical setting.

i. The MCP must include at least one Board Certified Psychiatrist, who shall be a prescriber, to perform the following BH Clinical Director functions:

1. Play a lead role in monitoring the overall safety of patients with a BH diagnosis, with a special focus on safe prescribing;

2. Serving as a key clinical lead in developing and implementing evidenced based clinical policies and practices;

3. Participating in regulatory/accreditation reviews;

4. Assuming key role in quality improvement initiatives, case management activities and member safety activities (i.e. incident management);

ii. All other duties and responsibilities of the BH Clinical Director staff shall include:

1. BH coverage determination for utilization management to ensure members receive appropriate and medically necessary care in the most cost-effective setting;

2. Oversight and quality improvement activities associated with case management activities;

3. Providing guidance to BH orientation and network development/ recruitment in conjunction with provider relations, value-based contracting, support of

episodes of care and full integration of BH services;

4. Assisting in the review of utilization data to identify variances in patterns, and providing feedback and education to MCP staff and providers as appropriate; and

5. Representing the MCP as the primary clinical liaison to members, providers and ODM.

e. **Contract Compliance Officer** who will serve as the primary point-of-contact for all MCP operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to: coordinating the tracking and submission of all contract deliverables, fielding and coordinating responses to ODM inquiries, coordinating the preparation and execution of contract requirements, random and periodic audits, and site visits.

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

g. **Care Management (CM) Director** who is an Ohio-licensed registered nurse or an Ohio-licensed independent social worker preferably with a designation as a Certified Case Manager (CCM) from the Commission for Case Manager Certification (CCMC). The CM Director is responsible for overseeing the day-to-day operational activities of the Care Management Program in accordance with state guidelines. The CM Director is responsible for ensuring the functioning of care management activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating). The CM Director shall have experience in the activities of care management as specified in 42 CFR 438.208. Primary functions of the CM Director position are to ensure:

   i. The implementation of mechanisms for identifying, assessing, and developing a treatment plan for an individual with special health care needs;

   ii. Access to primary care, behavioral health, and coordination of health care services for all members; and

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

h. **Utilization Management (UM) Director** who is an Ohio-licensed registered nurse or a physician with a current unencumbered license through the Ohio State Medical Board preferably with a certification as a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The UM Director is responsible for overseeing the day-to-day operational activities of the Utilization Management Program in accordance with state guidelines. The UM Director shall have experience in the activities of utilization management as specified in 42 CFR 438.210. Primary functions of the Director of Utilization Management position are to ensure:

i. There are written policies and procedures regarding authorization of services and that these are followed;

ii. Consistent application of review criteria for authorization decisions;

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

iv. Notices of adverse action meet the requirements of 42 CFR 438.404; and

v. All decisions are made within the specified allowable time frames.

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

i. Ensuring receipt of all EPSDT services;

ii. Ensuring receipt of maternal and postpartum care;

iii. Promoting family planning services;

iv. Promoting preventive health strategies;

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

vi. Interfacing with community partners; and

vii. Pregnancy Related Services Coordinator

j. **Quality Improvement (QI) Director** is a member of the MCP QI leadership team who is either an Ohio-licensed registered nurse, physician or physician's assistant, or who is certified as a CPHQ by the National Association for Healthcare Quality, CQIA by the American Society for Quality (ASQ), and/or a CHCQM by the American Board of Quality Assurance and Utilization Review Providers (ABQAURP) within six months of employment. The QI Director shall have experience in quality management and quality improvement as specified in 42 CFR 438.206 through 438.370. The primary functions of the QI Director position are:

i. Developing and managing the MCP's portfolio of improvement projects, including identifying and prioritizing initiatives;

ii. Assisting the MCP's leadership team in communicating the cross-cutting nature of improvement efforts and their relationship to the MCP and ODM quality strategies and improved state health outcomes;

iii. Ensuring individual and systemic quality of care and services through modeling and encouraging systems thinking;

iv. Assisting the MCP leadership team (as defined in Appendix K) in integrating quality throughout the organization's culture through working with staff from different program areas to identify improvement opportunities, test improvement strategies using proven methods, and assess results using frequent measurements;

v. Supporting MCP improvement teams in the execution of quality improvement projects, including elevating resource, IT, analytic, and staffing needs by bringing to the attention of the leadership team;

vi. Ensuring appropriate members of MCP improvement teams are fully prepared for QI discussions with ODM (i.e. team members should be able to independently describe the current status of intervention testing, the theory of change, etc. for projects in which they are involved);

vii. Increasing MCP staff effectiveness through providing ODM-approved training in quality improvement science and reinforcing the application of quality improvement tools and methods within MCP improvement projects and initiatives;

viii. Articulating the methods, measures, and data used to determine choice and effectiveness of improvement activities;

ix. Incorporating the results of quality improvement assessments and evaluations into the MCP's quality strategy;

x. Monitoring, reporting, and presenting quality improvement initiative status and results over time, including lessons learned from failures, to both internal and external audiences to drive real time decision making; and

xi. Working collaboratively with all MCPs and ODM to improve population health outcomes, including addressing health equity and social determinants of health.

k. **Community Engagement Coordinator** is a position that formalizes current MCP engagement activities in priority communities. Depending on the size of the population being served, at least one full-time employee (FTE) will be devoted to Community Engagement Coordinator responsibilities. These responsibilities may be filled by multiple individuals. Community Engagement Coordinator responsibilities shall include:

i. Serving as the MCP's primary point(s) of contact for ODM-sanctioned improvement efforts involving community-based organizations and requiring community outreach and active involvement in priority communities (e.g., community-based infant mortality

reduction);

ii. Attending or overseeing MCP attendance at community events in priority communities (e.g., trainings, racism dialogues, infant mortality awareness events);

iii. In-person communication with funded community-based organizations (CBOs) in order to bolster the presence of the MCP itself as a collaborative and trusted partner of the CBO and as a supporter of the ODM initiative;

iv. Collaborating with other MCPs' coordinators to communicate and address community concerns;

v. Coordinating the tracking and submission of process measures, as needed, related to MCP improvement efforts in communities (e.g. infant mortality reduction efforts in high priority areas);

vi. Promoting referral of members to CBOs when services are provided that will promote better pregnancy outcomes (e.g., Centering Pregnancy);

vii. Responding to ODM inquiries related to MCP community engagement activities; and

viii. Identifying additional community engagement opportunities and developing a Community Engagement Plan to participate in or support those opportunities. The Community Engagement Plan shall be submitted as specified by ODM.

l. **Transition Coordinator** who will serve as the primary point of contact for planning and managing all MCP transition activities associated with MCP termination and/or nonrenewal, as identified in Appendix P. The primary functions of the Transition Coordinator include, but are not limited to:

i. Coordinating the development and submission of the MCP's transition plan;

ii. Coordinating the tracking and submission of all transition-related reports and deliverables;

iii. Coordinating MCP representation and attendance for ODM identified transition meetings;

iv. Coordinating and overseeing all member transition activities to ensure the safe;

v. Timely and orderly transition of members and their care; and

vi. Coordinating the development of submission of MCP transition plan updates and final report to ODM.

9. Upon request by ODM, the MCP 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 MCP shall ensure employees, including subcontractor staff, receive training on applicable program requirements, and represent, warrant, and certify to ODM that such training occurs, or has occurred. Training will be commensurate with provider function and will include at a minimum an introduction to: behavioral health benefits, evidence-based practices for both behavioral health and medical conditions, person-centered care delivery approaches, and other subjects as specified by ODM. Individuals who oversee training shall have demonstrable experience and expertise in the topic for which they are providing training.

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

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

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

14. The MCP is responsible for determining medical necessity for services and supplies requested for its members as specified in OAC rule 5160-26-03. Notwithstanding such responsibility, ODM retains the right to make the final determination on medical necessity in specific member situations. In accordance with OAC rule 5160-26-03.1, the MCP shall make its medical necessity review policies and procedures available to ODM, as well as contracting and non-contracting providers.

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

16. **Provider Panel Changes.**

    a. In addition to the provisions in OAC rule 5160-26-05, the MCP shall notify the OMC in writing:

        i. Within one business day of becoming aware that an MCP panel provider that served 500 or more of the MCP's members in the previous 12 months failed to notify the MCP that they are no longer available to serve as an MCP panel provider;

        ii. No less than 90 days before the end date of an MCP initiated, without cause termination of a provider subcontract when the provider has served 500 or more of the MCP's members in the previous 12 months. This includes individual practitioners in group practices which cumulatively have served 500 or more members in the previous 12 months. MCP-initiated terminations of provider subcontracts that have served 500 or more of the MCP's members may not take effect during the 90 days after the open

enrollment month ends;

iii. Prior to any MCP-initiated provider panel changes that will result in provider network availability being reduced by 10% or more of available panel providers as of the date of the notice. MCP-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

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

b. When a plan has been notified of a hospital termination, the MCP may request ODM authorize an alternative notification area, in accordance with OAC rule 5160-26-05. Upon request, ODM will determine the authorized notification area no later than 7 business days after receipt of the MCP's submission. The notification timelines outlined in OAC rule 5160-26-05 will not be waived. The MCP 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 MCP may elect to provide services in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Before the MCP notifies potential or current members of the availability of those services, the MCP shall first notify ODM of its plans to make such services available. If the MCP elects to provide additional services, the MCP shall ensure to the satisfaction of ODM that

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

a. The MCP 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 MCP pursuant to OAC rule 5160-26-03 and Appendices G and H of this Agreement. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.

b. The MCP shall give ODM and members 90 calendar days prior notice when decreasing or ceasing any additional benefits. When the MCP finds that 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 MCP shall ensure protocols, policies, and processes are in place for MCP 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 that the individual received the needed services (e.g. connection to crisis counseling services), and the ability to activate the MCP's process 24/7.

19. **Provision of Transportation Services.** The MCP 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 following a scheduled appointment. The vendor shall attempt to contact the member if he/she does not respond at pick-up.

    a. The transportation vendor shall not leave the pick-up location prior to the pre-scheduled pick-up time.

    b. The MCP shall identify and accommodate any special transportation assistance needs of their 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. The MCP shall submit a plan for the provision of transportation services during winter snow and other weather emergencies, specifying identification, triage, transportation of consumers requiring critical services, notification to consumers of canceled transportation and rescheduling. The plan shall specify the snow emergency level and any other weather-related criteria that require a change to scheduled transportation. The MCP shall notify the Contract

Administrator immediately when transportation is canceled in accordance with the plan.

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

21. **Cultural Competency and Communication Needs.** The MCP 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/clas), 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 identity. The MCP 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 MCP shall comply with the requirements specified in OAC rules 5160-26-03.1, 5160-26-05, and 5160-26-05.1 for providing assistance to LEP members and eligible individuals. In addition, the MCP shall provide written translations of certain MCP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

    a. If ODM identifies prevalent non-English languages in the MCP's service area, the MCP, as specified by ODM, shall translate marketing and member materials, including but not limited to HIPAA privacy notices, into the primary languages of those groups. The MCP shall make these marketing and member materials available to eligible individuals free of charge.

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

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

    d. The MCP shall submit to ODM, upon request, information regarding the MCP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the MCP as well as those services reported to the MCP which were arranged by the provider).

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

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

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

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

    a. Informing members about Healthchek, the MCP 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. The MCP may meet this requirement by including information with the new member materials as specified in Appendix F. In addition, the MCP may be required to communicate with the member's local county department of job and family services (CDJFS) 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 MCP'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 individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document entitled "Recommendations for Preventive Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics;

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

            4. Information that providers may request prior authorization for:

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

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

iii. Provide the information included in the member handbook above regarding Healthchek on the MCP's member website specified in this appendix.

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

1. When the member is 9 months old;

2. When the member is 18 months old;

3. When the member is 30 months old;

4. January of each calendar year to all members under the age of 21; and

5. In July for members from age 4 to under 21.

6. When the member is identified as pregnant.

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 MCP 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):

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

ii. The MCP 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 MCP 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 5160-01-14;

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 MCP's provider website as specified in this appendix.

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

23. **Advance Directives**. The MCP 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 MCP to ensure the MCP:

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

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 MCP's policies and procedures on advance directives;

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

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

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

24. **Call Center Standards.** The MCP shall provide assistance to members and providers through a toll-free call-in system.

a. Provider call center standards.

i. 85% of calls answered within 120 seconds.

ii. Maintain a capture rate of 95%.

iii. At least semi-annually, the MCP shall self-report its monthly and semi-annual performance in the following three areas for their Provider Call Center, as specified: capture rate, average call time, and average speed of answer. If the MCP has separate telephone lines for different Medicaid populations, the MCP shall report performance for each individual line separately. The MCP shall report their July through December performance to ODM by January 10th and their January through June performance by July 10th. ODM reserves the right to require more frequent reporting by the MCP if ODM becomes aware of what is perceives to be an access issue or consecutive months of noncompliance.

b. The Member telephone system shall have services available to assist:

i. Hearing-impaired members; and

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

c. The member services program shall assist MCP members, and as applicable, eligible individuals seeking information about MCP membership with the following:

i. Accessing Medicaid-covered services;

ii. Obtaining or understanding information on the MCP's policies and procedures;

iii. Understanding the requirements and benefits of the plan;

iv. Resolution of concerns, questions, and problems;

v. Filing of grievances and appeals as specified in OAC rule 5160-26-08.4;

vi. Obtaining information on state hearing rights;

vii. Appealing to or filing directly with the U.S. Department of Health and Human Services Office of Civil Rights any complaints of discrimination on the basis of race, color, national origin, age, or disability in the receipt of health services;

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

ix. Accessing sign language, oral interpretation, and oral translation services. The MCP shall ensure these services are provided at no cost to the eligible individual or member. The MCP shall designate a staff person to coordinate and document the provision of these services.

d. In the event the consumer contact record (CCR) does not identify a member-selected primary care provider (PCP) for each assistance group member, or if the member-selected PCP is not available, the MCP shall:

i. Select a PCP for each member based on the PCP assignment methodology prior-approved by ODM;

ii. Simultaneously notify each member with an MCP-selected PCP of the ability within the first month of initial MCP membership to change the MCP-selected PCP effective on the date of contact with the MCP; and

iii. Explain that PCP change requests after the initial month of MCP membership shall be processed according to the procedures outlined in the MCP member handbook.

e. MCP member services staff shall be available nationwide to provide assistance to members through the toll-free call-in system every Monday through Friday, at all times during the hours of 7:00 am to 7:00 pm Eastern Time, except for the following major holidays: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

f. Two optional closure days can be used independently or in combination with any of the major holiday closures, but cannot both be used within the same closure period. Before announcing any optional closure dates to members and/or staff, the MCP shall receive ODM prior approval which verifies that the optional closure days meet the specified criteria.

g. If a major holiday falls on a Saturday, the MCP member services line may be closed on the preceding Friday. If a major holiday falls on a Sunday, the member services line may be closed on the following Monday. MCP member services closure days shall be specified in the MCP's member handbook, member newsletter, or other some general issuance to the MCP's members at least 30 calendar days in advance of the closure. The MCP shall request prior approval from ODM of any extended hours of operation of the member services line outside the required days and time specified above.

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

i. The MCP shall meet the current American Accreditation HealthCare Commission/URAC-designed Health Standards (HCC) for call center abandonment rate, blockage rate, and average speed of answer. At least semi-annually, the MCP shall self-report its monthly and semi-annual performance in these three areas for their member services and 24/7 hour toll-free call-in systems to ODM as specified. If the MCP has separate telephone lines for different Medicaid populations, the MCP shall report performance for each individual line separately. The MCP 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 MCP if it becomes aware of an egregious access issue or consecutive months of noncompliance with URAC standards. ODM will inform the MCP of any changes/updates to these URAC call center standards.

j. The member services call center requirement may not be delegated through a sub-contractual relationship as specified in this appendix, without prior approval by ODM. With the exception of transportation vendors, the MCP is prohibited from publishing a delegated entity's general call center number.

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

26. **Privacy Compliance Requirements**. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations at 45 CFR.164.502(e) and 164.504(e) require ODM to enter into agreements with MCPs as a means of obtaining satisfactory assurance that the MCPs will appropriately safeguard all "protected health information" (PHI), which means information received from or on behalf of ODM that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 CFR 160.103, 45 CFR 164.501, and any amendments thereto.

    In addition to the HIPAA requirements, the MCP 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 MCP acknowledges that ODM is a Covered Entity under HIPAA. A Covered Entity means a health plan, a health care clearinghouse, or health care provider under 45 CFR 160.103. The MCP further acknowledges that it is a Business Associate of ODM. A Business Associate means a person or entity that, on behalf of the Covered Entity, maintains, performs, or assists in the performance of a function or

activity that involves the use or disclosure of "Protected Health Information" under 45 CFR 160.103. The MCP, as a Business Associate agrees to comply with all of the following provisions:

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

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

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

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

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

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

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

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

limited to information created by the MCP.

i. **Accounting for Disclosure**. The MCP shall maintain and make available to ODM or individuals requesting the information as appropriate, records of all disclosures of PHI in a Designated Record Set as necessary to satisfy ODM's obligations under 45 CFR 164.528. For every disclosure, the record 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 MCP is required to carry out an obligation of ODM under Subpart E of 45 CFR Part 164, the MCP agrees to comply with all applicable requirements of Subpart E that would apply to ODM in the performance of such obligation.

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

l. **Material Breach**. In the event of material breach of the MCP's obligations under this Article, ODM may immediately terminate this Agreement as set forth in 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 MCP will return to ODM or destroy all PHI in MCP's possession stemming from this Agreement as soon as possible but no later than 90 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 MCP, its agent(s), or subcontractor(s) destroy any PHI, then the MCP will provide to ODM documentation evidencing such destruction. Any PHI retained by the MCP will continue to be extended the same protections set forth in this section, HIPAA regulations, and this Agreement for as long as it is maintained.

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

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

28. **Managed Care Day One.** Individuals will enroll in managed care beginning the first day of the month in which Medicaid eligibility is determined. There will be no fee-for-service time period for most services. For members identified on the 834C as being determined Medicaid eligible, during their first month of managed care enrollment the MCP shall pay for all medically-necessary covered services provided during the first month.

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

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

    b. **Plan PBM Contractor.** Eligibility additions for the current month received in the 834C file must be sent to the MCP's PBM within 24 hours of the MCP's receipt of the file, except during state cutoff when plans have the option to follow the 834 file loading process as stated in the 834 companion guide.

    c. **Monthly Remittance Advice.** The HIPAA 820 (Monthly Remittance Advice) will contain the following: a capitation payment for each member listed on the HIPAA 834F monthly file, a capitation payment/recoupment for changes listed in the daily HIPAA 834C daily files, any other capitation payment/recoupment, and delivery payment/recoupment from the previous calendar month.

    d. **Enrollment and Monthly Capitation Reconciliation**. The MCP shall maintain the integrity of its membership data through processing and loading of data contained for each individual in the daily HIPAA 834C (Daily Benefit Enrollment and Maintenance) files and reconciling the daily changes with the monthly HIPAA 834F (Monthly Benefit Enrollment and Maintenance) file. 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 of enrollment(s)/Disenrollment(s) contained on the HIPAA 834 files and HIPAA 820 file, for the associated 834 files, is due and shall be submitted, no later than 60 calendar days after the issuance of the HIPAA 820 payment file.

    e. **Reconciliation Request Format**. All reconciliation requests shall be submitted in the format specified by ODM. Reconciliation requests submitted after the initial 60 calendar day due date may be rejected by ODM and will be processed at ODMs discretion. No reconciliation requests for enrollment and/or payment will be accepted beyond 18 months after the capitation/enrollment month. Reconciliations for ODM recoupment of capitation payments will always be processed. Newborn reconciliations where no Medicaid billing ID has been received on the 834 file will not be accepted beyond the month in which the newborn turns 13 months.

    f. **Change in Member Circumstance.** In accordance with 42 CFR 438.608, the MCP shall notify ODM that a member is deceased no later than 30 calendar days after being notified of the date of death. The notification must be made following the submission guidelines, and in the format prescribed by ODM.

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

    h. **MCP-Initiated Nursing Facility (NF) disenrollment requests**. Excluding Adult Extension, pursuant to OAC rule 5160-26-02.1, MCP-initiated nursing facility (NF) disenrollment requests for MAGI

and ABD shall be submitted in the format specified by ODM. See disenrollment table below:

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

i. If a member is admitted to a NF while enrolled with the MCP and the MCP disenrollment request is submitted after the Earliest Disenrollment Date, the member will be disenrolled as of the last calendar day of the submission month.

ii. When a member is admitted to a NF while enrolled with one MCP, then changes to a different MCP, either:

    1. The admission date is three months or less prior to the initial enrollment month, and the MCP disenrollment request shall align with the Disenrollment Table dates; or

    2. The admission date is more than three months prior to the initial enrollment month, and the MCP disenrollment request shall be submitted during the initial enrollment month to disenroll the member the last calendar day of the month prior to the initial enrollment.

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

iv. In instances where the initial enrollment month is accompanied by an enrollment span with a start reason of First Month Enrollment (FME) due to Day 1 Managed Care enrollment, the FME span will also be removed. For example, if HIPAA 834 contains a 1/1/2018 to 1/31/2018 enrollment with an FME start reason and a 2/1/2018 to 12/31/2299 enrollment with ASG start reason then:

    1. The MCP submits a NF disenrollment request on 2/12/2018, which is prior to 2/28/2018. Both the initial enrollment of 2/1/2018 and FME of 1/1/2018 will be

deleted.

2. The MCP submits a NF disenrollment request on 3/15/2018, which is after 2/28/2018. The FME of 1/1/2018 to 1/31/2018, the initial enrollment of 2/1/2018 through the month of submission (3/31/2018) will be covered by the Managed Care Plan.

v. In all cases, the MCP is responsible for coverage of services and payment through the disenrollment date.

i. **Change in Enrollment During Hospital/Inpatient Facility Stay.** When the MCP learns of a currently hospitalized member's intent to disenroll through the CCR or the HIPAA 834, the disenrolling MCP shall notify the hospital/inpatient facility and treating providers as well as the enrolling MCP, if applicable, of the change in enrollment. The disenrolling MCP 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 MCP shall not request and/or require that a disenrolled member be discharged from the inpatient facility for transfer to another inpatient facility. Should a discharge and transfer to another inpatient facility be medically necessary, the disenrolling MCP shall notify the treating providers to work with the enrolling MCP or ODM as applicable to facilitate the discharge, transfer, and authorization of services as needed.

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

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

j. **Just Cause Requests**. As specified in OAC rule 5160-26-02.1, the MCP shall assist in resolving member-initiated Just Cause requests affecting membership.

k. **Newborn Notifications**. MCP membership for newborns will be in accordance with OAC rule 5160-26-02, unless otherwise notified by ODM. In order to encourage the timely addition of newborns, authorization for Medicaid, and enrollment in the MCP, the MCP shall provide

notification of the birth to the CDJFS within the earlier of five business days of birth or immediately upon learning of the birth. The MCP shall provide the mother's name, social security number, eligibility system case number, 12 digit recipient ID, county of eligibility, and the newborn's name, gender, and date of birth in format designated by ODM. The information shall be sent to the CDJFS again at 60 calendar days from the date of birth if the MCP has not received confirmation by ODM of a newborn's MCP membership via the membership roster. If no newborn information is provided by the CDJFS within two weeks after the 60 day submission, the MCP shall follow established reconciliation procedures.

l. **Eligible Individuals**. If an eligible individual, as defined in OAC rule 5160-26-01, contacts the MCP, the MCP shall provide any MCP-specific managed care program information requested. The MCP 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 MCP shall provide an assurance that all MCPs shall cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.

m. **Pending Member**. If a pending member (i.e., an eligible individual subsequent to MCP selection or assignment to an MCP, but prior to their membership effective date) contacts the selected MCP, the MCP shall provide any membership information requested, including but not limited to explaining how to access services as an MCP member and assistance in determining whether current services require prior authorization. The MCP 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 MCP's system and forwarded to the appropriate MCP staff for processing as required.

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

n. **Member Reimbursement**. Upon implementation of the amended rule, the MCP 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 MCP shall accept the ODM approved direct reimbursement packet and begin the direct reimbursement process. If the MCP is the first contact a member makes regarding direct reimbursement, the MCP shall begin the direct reimbursement process but may use their own process and documents.

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

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

a. The MCP shall follow the Medicaid behavioral health coverage policies described in OAC chapter 5160-27, including utilization management requirements, except that the MCP may implement less restrictive policies than FFS.

b. The MCP shall allow a member who was receiving behavioral health services prior to July 1, 2018 to continue to receive services with an out-of-network provider through October 1, 2020, if the provider is enrolled as a Medicaid provider with ODM. Prior to October 1, 2020, the MCP must work with members receiving behavioral health services from out-of-network providers as necessary to ensure a smooth transition to network providers. After October 1, 2020, if a member is unable to obtain medically necessary services from an MCP network provider, the MCP must adequately and timely cover the services out-of-network until the MCP is able to provide the services from a network provider. For continuity of care purposes, the MCP will:

i. Work with the service provider to add the provider to their network;

ii. Implement a single case agreement with the provider; or

iii. Assist the member in finding a provider currently in the MCP's network.

c. The MCP shall maintain Medicaid FFS payment rates as a floor for behavioral health services implemented through behavioral health redesign on July 1, 2018 when the MCP's provider contracts are based on FFS rates. This does not apply to CBHC Laboratories or services added to the behavioral health benefit package after May 1, 2020.

32. **Retroactive Coverage Requirements.** The MCP shall pay for claims for covered services provided to members during retroactive enrollment periods. For services provided during retroactive enrollment periods that require FFS prior authorization as documented in Appendix DD of OAC rule 5160-1-60, OAC rule 5160-9-03 (regarding pharmacy claims), and all other FFS regulations that set forth prior authorization policy, the MCP may conduct a medical necessity review for payment. However, if the service was already reviewed and approved by FFS, the MCP shall also approve the service.

33. **Transition of Care Requirements for New Members.** The MCP shall follow the transition of care requirements as outlined below for any new member, regardless of if the individual is transitioning from FFS or another MCP.

a. Upon notification from ODM that an individual will be switching to a different MCP or MyCare Ohio plan, the disenrolling MCP shall provide specific information related to the disenrolling member to the enrolling plan as specified by ODM.

b. **Continuation of Services for Members**. The MCP shall allow a new member to receive services from network and out-of-network providers, as indicated, if any of the following apply:

i. If the MCP confirms that the Adult Extension member is currently receiving care in a nursing facility on the effective date of enrollment with the MCP, the MCP shall cover the nursing facility care at the same facility until a medical necessity review is completed and, if applicable, a transition to an alternative location has been documented in the

member's care plan.

ii. Upon becoming aware of a pregnant member's enrollment, the MCP shall identify the member's maternal risk and facilitate connection to services and supports in accordance with ODM's *Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services.* These services and supports include delivery at an appropriate facility and continuation of progesterone therapy covered by Medicaid FFS or another MCP for the duration of the pregnancy. In addition, the MCP shall allow the pregnant member to continue with an out-of-network provider if she is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.

iii. The MCP shall honor any prior authorizations approved prior to the member's transition through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with the MCP.

1. The MCP may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCP must render an authorization decision pursuant to OAC rule 5160-26-03.1.

2. The MCP may assist the member to access services through a network provider when any of the following occur

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

b. The member chooses to change to a network provider; or

c. If there are quality concerns identified with the previously authorized provider.

3. Scheduled inpatient or outpatient surgeries approved and/or pre-certified shall be covered pursuant to OAC rule 5160-2-40 (surgical procedures would also include follow-up care as appropriate);

4. Organ, bone marrow, or hematopoietic stem cell transplant shall be covered pursuant to OAC rule 5160-2-65 and Appendix G of this Agreement;

iv. The MCP shall provide the following services to the member regardless of whether services were prior authorized/pre-certified or the treating provider is in or out-of-network with the MCP:

1. Ongoing chemotherapy or radiation treatment;

2. Hospital treatment plan (if member was released from hospital 30 days prior to enrollment);

3. Private duty nursing, home care services, and Durable Medical Equipment (DME) shall be covered at the same level with the same provider as previously covered until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.

4. Prescribed drugs shall be covered without prior authorization (PA) for at least the first 90 days of membership, or until a provider submits a prior authorization and the MCP completes a medical necessity review, whichever date is sooner. The MCP shall educate the member that further dispensation after the first 90 days will require the prescribing provider to request a PA. If applicable, the MCP shall offer the member the option of using an alternative medication that may be available without PA. Written member education notices shall use ODM-specified model language. Verbal member education may be substituted for written education but shall contain the same information as a written notice. Written notices or verbal member education shall be prior approved by ODM.

5. Upon notification from a member and/or provider of a need to continue services, the MCP shall allow a new member to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services.

c. **Out-of-Network Provider Reimbursement**. The MCP shall reimburse out-of-network providers who provide services during the transition at 100% of the current Medicaid FFS provider rate for the specific service.

d. **Documentation of Services**. The MCP shall document the provision of transition of services as follows:

i. The MCP shall seek confirmation from an out-of-network provider that the provider agrees to provide the service and accepts the Medicaid FFS rate as payment.

1. If the provider agrees, the MCP shall distribute materials to the out-of-network provider as specified in Appendix G of this Agreement.

2. If the provider does not agree, the MCP shall notify the member of the MCP's availability to assist with locating another provider as expeditiously as the member's health condition warrants.

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

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

e. **Pre-Enrollment Planning.** The MCP shall utilize data provided by ODM or an MCP and/or collected by the MCP through assessments, new member outreach in advance of the member's enrollment effective date, etc., to identify existing sources of care and to ensure each new member is able to obtain continuation of services in accordance with this appendix.

f. **Provision of Care Management**. In accordance with Appendix K, the MCP shall assess new members using the standardized health risk assessment tool within 90 calendar days of enrollment for the purpose of risk stratification and to identify potential needs for care management.

34. **Medicare Payment Guidelines for Managed Care Members in Receipt of Medicare.** During transition and/or when a member exhausts their Medicare lifetime benefit, unless the provider has expressly agreed to quality incentives and a different secondary claims payment rate, not including simple rate changes proposed by the MCP, the MCP shall adjudicate Medicare secondary claims as 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.

35. **Health Information System Requirements**. The ability to develop and maintain information management systems capacity is crucial to successful plan performance. ODM therefore requires the MCP to demonstrate their ongoing capacity in this area by meeting several related specifications.

a. **Health Information System**.

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

ii. As required by 42 CFR 438.242(b)(1), the MCP 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 MCP 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)(3), the MCP 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 MCP may submit production files;

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

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

vi. When the MCP 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 MCP can return to submitting production files. ODM will inform the MCP in writing when a test file is acceptable. Once the MCP's new or modified information system is operational, the MCP 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 MCP's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period.

b. **Electronic Data Interchange (EDI), Claims Adjudication and Payment Processing Requirements.**

i. **Timely Filing for Behavioral Health (BH) Claims.** The MCP shall accept claims for BH services described in OAC Chapter 5160-27 for 365 calendar days from the date of service.

ii. **Claims Adjudication**. The MCP 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 MCP shall inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information shall be initiated by the MCP and not only in response to provider requests.

iii. The MCP shall notify providers who have submitted claims of claims status (paid, denied, and all claims not in a final paid or denied adjudicated status [hereinafter referred to as "pended/suspended"])) within one month of receipt by the MCP or its designee. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly, or more frequent, basis. If a provider and/or a provider's clearinghouse submits a HIPAA compliant 276 EDI transaction to the MCP and/or the MCP's clearinghouse, the MCP/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 MCP 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 inpatient only procedure listing

(determined by Medicare and 3M) that ODM uses to process fee-for-service claims.

1. For inpatient hospital claims, the MCP 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 MCP shall use the 3M Enhanced Ambulatory Patient Grouping (EAPG) and utilize the same version that ODM uses.

v. **Electronic Visit Verification (EVV).** The MCP 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. The MCP shall 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 MCP shall inform providers of the use of the EVV data collection system and how the data will be utilized by the MCP. The MCP 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 MCP shall submit a monthly report of all EVV related claims that would have denied as specified by ODM. Upon full implementation of EVV, the MCP shall submit a monthly report of all EVV related denied claims as specified by ODM.

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

vii. **Claims Payment Systemic Errors (CPSEs).** For the purpose of this appendix, a CPSE is defined as the MCP's claims adjudication, including claims adjudication by a contracted vendor, either electronic or manual, incorrectly underpaying, overpaying, or denying claims. that impact, or has the potential to 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 MCP shall submit the CPSE report and all communications to MedicaidCPSE@medicaid.ohio.gov, unless otherwise directed by ODM, based on the ODM calendar of submissions schedule. A late or incomplete submission is subject to sanctions in accordance with non-compliance with CPSEs in Appendix N of this Agreement.

2. The MCP shall follow all instructions as directed by ODM, including the CPSE reporting template instructions and guidelines.

3. The MCP shall inform ODM of the status of all active CPSEs on the monthly report by including the following:

    a. A detailed description and scope of all active CPSEs; ;

    b. The date the CPSE was first identified;

    c. The type(s) of all providers impacted;

    d. The number of providers impacted;

    e. The date(s) and method(s) of all provider notifications ;

    f. The timeline for fixing the CPSE;

    g. The date(s) or date span(s) for all claim adjustment projects or notifications of claim overpayments, if applicable.

4. The MCP shall report all CPSEs on a monthly CPSE report housed on the MCP's Ohio Medicaid website.

    a. The CPSE report shall be public facing for anyone to view and/or on the MCP's provider portal. If the provider portal is used, timely communication of the CPSE must also be made to those impacted providers who are unable to access the CPSE report;

    b. The CPSE report shall be updated at a minimum once a month, labeled to reflect the updated date;

    c. The CPSE report shall include, at a minimum, the following information:
        i. A detailed description and scope of all CPSEs;

        ii. The date of first identification;

        iii. The type(s) of provider(s) impacted;

        iv. The timeline for fixing the CPSE;

        v. The date of claims adjustments or required provider action.

5. The MCP shall have a policy and procedure to identify, communicate, and correct CPSEs. The MCP shall keep the CPSE policy and procedure current to reflect the CPSE requirements. ODM reserves the right to review these and request changes if necessary. The MCP shall include, at a minimum, all the following in their CPSE policy and procedure:

a. The use of input from internal and/or external sources to identify a CPSE, including but not limited to:

   i. User acceptance testing (UAT) activities;

   ii. Claims processing activities;

   iii. Provider complaints/inquiries; and

   iv. ODM inquiries.

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

c. A description of the process, including timelines, to escalate from initial identification to definition of the error;

d. A description of the process and timeline to determine root cause of the issues, including UAT testing;

e. The timeframe to re-adjudicate claims, if applicable, or notify providers of an overpayment and the process for providers to dispute those actions;

f. The description of the process to complete and submit a completed CPSE report monthly to ODM, to report the status of CPSEs as specified above; and

g. A communication process, including timelines, to timely notify providers of identified CPSEs as directed above, including any other appropriate methods such as phone calls, emails, etc.

viii. The MCP 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 MCP shall load rate changes into applicable systems by either the rate change implementation date or within 25 calendar days of being notified by ODM of the change, whichever date is later. The effective date of the rate change shall be the date specified by ODM, regardless of when the MCP's system(s) are updated. If necessary, the MCP shall backdate the effective date and reprocess claims to ensure any claim received after the effective date of the rate change is adjudicated accurately.

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

xi. The MCP 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. The MCP shall provide accurate written notification as described in ORC section 5167.22 to providers at least 14 calendar days (unless otherwise stated in the plan/provider contract) in advance when the MCP is recovering payments that were incorrectly paid for reasons other than fraud, waste, and abuse.

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

1. The MCP shall acknowledge receipt of a HealthTrack complaint within 5 business days of the complaint's submission by 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 MCP will respond by the assigned due date.

2. The MCP shall document initial provider contact within 6 business days of the complaint's submission, including the following:

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

    b. A call reference number if applicable;

    c. The method(s) of contact;

    d. The person that made the contact; and

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

3. The MCP shall perform internal research, contact the provider, and present its findings to the provider within 15 business days.

    a. Provider Contact shall include:

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

        ii. The assigned provider representative's contact information;

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

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

or procedures.

b. If the provider is non-responsive, prior to closure of the complaint, a minimum of three outreach attempts must be made to the provider by the MCP.

c. The MCP shall document the following in HealthTrack by the assigned due date:

i. The date(s) contact was made, including all attempted contacts, with the provider (a future date of contact will not be accepted);

ii. The method(s) of contact;

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

iv. The findings shared with the provider;

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

vi. Root cause analysis or CPSE details. If already reported to ODM as a CPSE then the MCP shall include the report month and row number.

d. If the MCP requires additional time to research a provider complaint, the MCP shall:

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

ii. 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.

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

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

i. The MCP 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; and

3. Health care payment and remittance status.

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

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

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

vi. **Trading Partner Agreement with ODM**. The MCP 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.

d. **Encounter Data Submission Requirements.**

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

ii. For sub-contracted payment arrangements in which a vendor directly pays particular claims (i.e. delegated arrangements in which the delegate is responsible for paying claims on behalf of the MCP to providers), the MCP shall submit encounters that include the amounts paid by the vendor to the provider at the claim-level.

iii. **Acceptance Testing**. The MCP 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 this appendix.

iv. **Encounter Data File Submission Procedures**. 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 MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO. Pursuant to 42 CFR 438.606, the CEO or CFO remains responsible for certification regardless of delegated signee.

e. **IDSS Data Submission and Audit Report Requirements**. In accordance with 42 CFR 438.606, the MCP 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 MCP 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 MCP Self-Reported, Audited HEDIS Results.

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

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

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

ii. Review the completed ISCA and accompanying documents;

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

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

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

vi. Examine MCP processes for data transfers;

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

viii. Review MCP 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 MCP.

36. **Delivery (Childbirth) Payments for MAGI and Adult Extension Members**. The MCP will be reimbursed for MAGI and Adult Extension member childbirth deliveries identified in the submitted encounters, using the methodology outlined in the Modified Adjusted Gross Income (MAGI) and MAGI Adult Extension Delivery Payment Reporting Procedures and Specifications for ODM Managed Care Plans - MITS (ICD-10) document. The delivery payment represents: the facility and professional service costs associated with the delivery event, postpartum care rendered in the hospital immediately following the delivery event, and the additional costs associated with multiple birth events; no prenatal or neonatal experience is included in the delivery payment.

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

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

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

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

    e. **Timing of Delivery Payments**. The MCP will be paid monthly for deliveries. For example, payment for a delivery encounter submitted with the required encounter data submission in March, will be reimbursed in May. This payment will be a part of the weekly update (adjustment payment) in place currently. The third weekly update of the month will include the delivery payment. The remittance advice is in the same format as the capitation remittance advice which is sent once each month.

f. **Updating and Deleting Delivery Encounters**. The process for updating and deleting delivery encounters can be found in the Modified Adjusted Gross Income (MAGI) and MAGI Adult Extension Delivery Payment Reporting Procedures and Specifications for ODM Managed Care Plans - MITS (ICD-10) document.

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

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

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

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

40. **Information Required for MCP Websites.**

a. The MCP shall have a secure internet-based website for contracting providers through which providers can confirm a consumer's enrollment and through which providers can submit and receive responses to prior authorization requests (an email process is an acceptable substitute if the website includes the MCP's email address for such submissions).

b. The MCP 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. MCP contact information, including the MCP's designated contact for provider issues.

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

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

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

v. The MCP's internet provider directory as referenced in this appendix and Appendix H.

vi. A link to the ODM Unified Preferred Drug List (UPDL) at https://pharmacy.medicaid.ohio.gov/drug-coverage. If applicable, the MCP may post a separate preferred drug list (PDL) for any drugs not included in the UPDL.

vii. A notice of changes to the MCP's list of drugs requiring PA or any other service or device requiring prior authorization via their website 30 calendar days in advance. In addition, 30 calendar days prior to all PA requirement changes, the MCP 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 PA 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. The requirements and process for submitting an appeal related to Maximum Allowable Costs (MAC) for pharmacy providers on their website. Prior to implementation, the MCP shall submit its MAC appeal auditing process to ODM for approval to ensure a reasonable process is established for pharmacy providers.

xiii. The MCP's specific standards for specialty pharmacies to become network providers.

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

41. **Provider Feedback.** The MCP 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 MCP for activities such as provider performance improvement projects

that include incentive programs or the development of quality improvement programs.

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

43. **Trial Member Level Incentive Programs**. The MCP shall submit a description of a proposed trial member-level incentive program to ODM for review and approval prior to implementation. A trial member level incentive program is defined as a time limited monetary or non-monetary reward offered to a member who complies with the intended goals of the program as outlined by the MCP (e.g., recommended health screenings) in the submission. The incentive shall not be considered a medically-necessary Medicaid-covered service or an additional benefit as offered in the MCP's Member Handbook. The MCP should refer to the *Guidance Document for Managed Care Plan Submission for Trial Member Level Incentive Programs* for additional clarification. It is the MCP's responsibility to ensure that any incentive program complies with applicable state and federal requirements.

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

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

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

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

    a. The MCP 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 MCP shall not transfer PHI to any location outside the United States or its territories.

    b. Pursuant to 42 CFR 438.602(i), no MCP 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 MCP shall be located outside the United States or its territories.

48. **National Committee for Quality Assurance (NCQA) Accreditation.** The MCP shall hold and maintain, or shall be actively seeking and working towards, accreditation by the NCQA for the Ohio Medicaid line of business. The MCP shall achieve and/or maintain a minimum status of Accredited. If the MCP receives a

Provisional or Denied status from NCQA, the MCP will be subject to sanctions as noted in Appendix N. Compliance will be assessed annually based on the MCP's accreditation status posted on the NCQA 'Report Cards' webpage (https://reportcards.ncqa.org/) as of November 1st of each year.

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

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

49. **MCP Family Advisory Council.** The MCP shall convene an MCP Family Advisory Council at least quarterly in each region that the MCP serves consisting of the MCP's current members. The purpose of the Council is to engage members in such a way as to elicit meaningful input related to the MCP's strengths and challenges with respect to serving members. The composition of the group shall be diverse and representative of the MCP's current membership throughout the region with respect to the members' race, ethnic background, primary language, age, Medicaid eligibility category (Adult Extension, MAGI and ABD), and health status. As new populations are enrolled in managed care, the MCP shall actively pursue ensuring the Council's membership reflects the diversity of its enrolled population.

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

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

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

    c. Improvement recommendations developed by each Council.

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

51. **Nursing Facility Services**. For Medicaid covered nursing facility stays, the MCP shall evaluate the member's need for the level of services provided by a nursing facility. To make this decision, the MCP 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 MCP shall provide documentation of the member's level of care determination to the nursing facility. The MCP shall maintain a written record that the criteria were met, or if not met, the MCP shall maintain documentation that a Notice of Action was issued in accordance with OAC rule 5160-26-08.4. 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 MCP 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.

    At a minimum, the MCP shall pay nursing facility providers in accordance with ORC section 5165.15. Additionally, the MCP shall ensure accurate claims payment to nursing facility providers by appropriately modifying payment pursuant to OAC rule 5160-3-39.1 when a member has patient liability obligations or lump sum amounts. 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 MCP is prohibited from paying for nursing facility services during restricted Medicaid coverage periods (RMCP). The MCP shall utilize HIPAA compliant enrollment files for patient liability obligations and RMCPs.

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

    a. The ACA requires the MCP to pay the Annual Fee no later than September 30th (as applicable to each relevant year, the "Fee Year") with respect to premiums paid to the MCP in the preceding calendar year (as applicable to each relevant year, the "Data Year"), and continuing similarly in each successive year.

    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 that ODM shall make a payment or an adjustment to capitation to the MCP for the full amount of the Annual Fee allocable to this Agreement, as follows:

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

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

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

            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 MCP, ODM shall annually make this payment or adjustment to capitation separately from the regular capitation rate paid to the MCP.

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

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 MCP in the same position as the MCP would have been in had no Annual Fee been imposed upon the MCP. This provision shall survive the termination of the Agreement.

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

54. **Comprehensive Disaster/Emergency Response Planning**. The MCP 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 MCP shall notify its Contract Administrator immediately when the Comprehensive Disaster/Emergency Response Plan has been activated. The MCP shall make a current version of the approved Comprehensive Disaster/Emergency Response Plan available to all staff.

    a. The MCP 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 MCP; respond to directives issued by ODM; and cooperate with the local- and state-level Emergency Management Agencies. The MCP 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 MCP 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 MCP 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 MCP shall identify members who are at risk for harm, loss, or injury during any potential natural, technological, or manmade disaster. The MCP 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 MCP shall develop an individual-level plan with the member when appropriate. The MCP 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 including, but not limited to access to medication/prescriptions;

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

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

   iv. Be provided to the member.

55. **MCP Portfolio Expansion.** The MCP shall immediately report to ODM all arrangements wherein services or contracts may overlap with Medicaid plans when plans are seeking to expand their portfolios through contracts with other entities.

56. **Subcontractual Relationships and Delegation.** If the MCP'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 MCP shall ensure it has a written agreement with the FDR to perform administrative services as defined below on the MCP's behalf. The following requirements apply to all FDR agreements. Additional FDR requirements specific to Pharmacy Benefit Manager agreements are described in Appendix R of this Agreement.

    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 MCP 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 MCP by common ownership or control, and under an oral or written arrangement performs some of the administrative services under the MCP'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 MCP executing any FDR agreement (hereinafter referred to as "the FDR agreement review period"), the MCP 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 MCP and the FDR about any provisions in the proposed FDR agreement.

iii. The MCP 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 MCP shall either revise the proposed FDR agreement to ODM's satisfaction or otherwise the MCP 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 MCP 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 MCP in writing that the MCP 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 MCP 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 MCP 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. Upon request, the MCP shall disclose to ODM all financial terms and arrangements for payment of any kind that apply between the MCP, or the MCP's FDR, and any provider of a Medicaid service, except where federal and state law restricts disclosing the terms and arrangements. ODM acknowledges that such information may be considered confidential and proprietary and thus shall be held confidential by ODM as specified in Article VII of this Agreement.

g. If applicable, the MCP and FDR shall narrowly designate portions of any FDR agreement as proprietary information. Portions of any 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.

h. 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 MCP.

    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 "non-dual" or "non-dual and dual" the FDR will serve.

    iv. A provision stating that the FDR shall release to the MCP and ODM any information necessary for the MCP to perform any of its obligations under the MCP'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 MCP, ODM, its designee or other entities as specified by the Ohio Medical Assistance 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 MCP. 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 the MCP cannot or will not pay for the administrative services. This provision does not prohibit waiver entities from collecting patient liability payments from MCP 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 MCP'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 that result 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 MCP 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 MCP; or

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

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

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

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

xvi. A provision that all of the provisions applicable to the FDR of the Ohio Medical Assistance 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 Ohio Medical Assistance 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 MCP in fulfilling the MCP's obligations under the Ohio Medical Assistance Provider Agreement.

xviii. A provision that allows the MCP to obtain and gather data, documents, and information from FDRs for the purpose of any audit conducted by the Auditor of the State of Ohio per ORC Chapter 117.

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

i. Ensure the performance of the 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 that ensure there is no disruption in meeting its contractual obligations to ODM, if the FDR or the MCP terminates the arrangement between the FDR and the MCP.

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

k. 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.

l. Delegation requirements do not apply to care management arrangements between the MCP and a Comprehensive Primary Care Practice or Patient Centered Medical Home as cited in Appendix K.

m. In accordance with 42 CFR 438.602, the MCP 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 MCP that relates directly or indirectly to the performance of the MCP's obligations under this Agreement, not including a network provider.

57. **Appeals and Grievances.** The MCP shall have written policies and procedures for an appeal and grievance system for members in compliance with the requirements of OAC rule 5160-26-08.4 and 42 CFR 438 Subpart F and shall include the participation of individuals authorized by the MCP to require corrective action. The MCP 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 MCP, 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 MCP shall develop and implement written policies and procedures that ensure the MCP's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code. Upon request, the MCP's state hearing policies and procedures shall be made available for review by ODM. When the MCP is notified by BSH that a member has requested a state hearing, the MCP 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 MCP has no record that the member has requested a plan appeal pertaining to the state hearing request;

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

    Unless the timeframe for a member to file an appeal with the MCP is exhausted in accordance with OAC rule 5160-26-08.4, if the MCP confirms to BSH that there is no record of the member requesting a plan appeal, the MCP shall attempt to contact the member to initiate the plan appeal process.

b. **Logging and Reporting of Appeals and Grievances**. The MCP 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 MCP 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 MCP 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.

58. **Ohio Equity Institute (OEI) Data**. The MCP shall submit data files for ODM-sanctioned improvement efforts involving infant mortality in priority communities as specified by ODM. To better assist OEI communities in their infant vitality efforts, the MCP shall work with ODM to establish a collaborative work plan to be established by January 1, 2020.

59. **Ventilator Program.** The MCP 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**. The MCP shall implement clearly defined structures and processes to maximize the effectiveness of the care provided to members pursuant to OAC rule 5160-26-03.1.

    a. The MCP will participate in clinical and policy collaborative workgroups as specified by ODM to identify methods for improvement in the standardization of prior authorization processes and standards for services determined by ODM. The MCP will ensure appropriate subject matter experts are included and adhere to timelines established by ODM.

    b. Pursuant to the criteria in ORC section 5160.34(C), the MCP is prohibited from retroactively denying a prior authorization (PA) request as a utilization management strategy. In addition, the MCP 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(B)(9). Also, ORC section 5160.34 requires the MCPs establish a streamlined provider appeal process relating to adverse PA determinations.

    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 rule 5160-26-03.1.

    d. **Home Health Assessment Prior Authorization**. If the MCP requires a prior authorization for home health assessments, the MCP must complete their prior authorization review within 48 hours of the request.

61. **Notification of Plan Specific Policy Changes.** In instances when the MCP is required to provide notice to a provider regarding a change in policy as specified in this Agreement, the MCP 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 communication must include an outline or a summary specifying the changes and their impact to specific providers receiving the policy changes.

The sanctions for noncompliance 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 specifically stated in Ohio Administrative Code (OAC) Chapter 5160-26 or elsewhere in this Agreement.

1. ODM will provide the MCP 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 MCP 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 MCP to receive program updates and discuss program issues with ODM staff.

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

5. ODM will provide the MCP 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 MCP service areas. ODM will notify the MCP of any languages identified as prevalent for the purpose of translating marketing and member materials outlined in Appendix F.

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

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

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

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

11. **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 MCP members with an open enrollment notice which describes the managed care program and includes

information on the MCP options in the service area and other information regarding the managed care program as specified in 42 CFR 438.10.

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

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

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

12. **Membership Selection.**

    a. The Ohio Medicaid Consumer Hotline (henceforth 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 MCP or choosing a health care delivery option.

    b. Eligible individuals will be auto-assigned to an MCP at the discretion of ODM in accordance with 42 CFR 438.54.

    c. ODM or their designated entity shall provide Consumer Contact Records (CCRs) to the MCP on no less than a weekly basis. The CCRs are a record of each consumer initiated MCP enrollment, change, or termination, and each Hotline initiated MCP assignment processed through the Hotline.

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

13. **Monthly Premium Payment.** ODM will remit payment to the MCP 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 MCP 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 MCP's Accounts Payable (i.e. Pay 4 Performance, Primary Care Rate Increase, and Health Insurance Provider Fee) and Accounts Receivable (i.e. Penalty, Credit Balance) transaction on the MITS Provider Portal Report Tab.

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

15. ODM will regularly provide information to the MCP regarding different aspects of the MCP's performance including, but not limited to, information on MCP-specific and statewide external quality

review organization surveys, focused clinical quality of care studies, consumer satisfaction surveys, and provider profiles.

16. ODM or its designee reserves the right to review and audit the Pharmacy Benefit Manager (PBM) or Pharmacy Benefit Administrator (PBA) agreements between the MCP and a PBM or PBA to ensure the PBM or PBA is fulfilling its contractual obligations, as well as with federal and state requirements. The MCP shall be responsible for ensuring that any findings from these audits are corrected within the timeframe specified by ODM.

17. ODM or its designee, at least annually, will conduct a pricing analysis to identify trends in payment to chain pharmacies and non-chain pharmacies, including but not limited to, identifying cost trends and payments to chain pharmacies and non-chain pharmacies.

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

APPENDIX E

RATE METHODOLOGY

July 2020 Medicaid Managed Care Provider Agreement Rate Amendment Summary

July 1, 2020 through December 31, 2020

Ohio Department of Medicaid

June 17, 2020

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

Jason A. Clarkson, FSA, MAAA
Principal and Consulting Actuary

Milliman

Milliman

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APPENDIX 1: JULY 2020 RATE CHANGE SUMMARIES

I. Introduction & Executive Summary

This document is an abridged version of the file titled "July 2020 MMC Capitation Rate Amendment" dated June 16, 2020. Please refer to the certification report for a complete version of the July amendment to the calendar year 2020 Medicaid Managed Care capitation rate development documentation.

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the Ohio Department of Medicaid (ODM) to provide actuarial and consulting services related to the development of capitation rates for its Medicaid Managed Care (MMC) program. This report provides a summary of the methodology used in the development of an amendment to the certified calendar year (CY) 2020 capitation rates for effective dates beginning July 1, 2020. This report is an amendment to the documentation of the capitation rates developed for CY 2020. The previously certified capitation rates and the documentation of their development were published in the following correspondences provided by Milliman:

- CY 2020 MMC Capitation Rate Certification dated December 6, 2019
- CY 2020 MMC Capitation Rate Recertification dated May 18, 2020

We will refer to the combination of these documents as the Original certification. We updated the capitation rates to include new and revised program adjustments not reflected in the Original certification. **Unless otherwise stated, the methodology and assumptions utilized are consistent with the capitation certification documentation included in the Original report**. The capitation rates provided under 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).

At the time of this report, we acknowledge there is substantial uncertainty regarding the impact of the COVID-19 pandemic on future projections. It is possible that the COVID-19 pandemic could have a material impact on the capitation rates presented in this report. With the exception of the morbidity impact of increased caseload expected to be enrolled in July through December 2020, the impact of COVID-19 has been excluded from this analysis. It is our understanding that ODM amended the CY 2020 capitation rates for consideration of COVID-19[1]. The Ohio Department of Health (ODH) implemented healthcare restrictions in an attempt to reduce the numbers of Ohioans who become infected with COVID-19, including the cancelation of all non-essential medical surgeries and procedures beginning March 18, 2020[2]. As this information was not reflected when developing the CY 2020 capitation rates, ODM elected to pursue a reduction to the CY 2020 capitation rates. Based on 42 CFR 438.7(c)(3), an amended capitation rate certification is not required for adjustments that increase or decrease capitation rates by 1.5% or less. As a result, we recognize that contracted capitation rates may differ from the information illustrated in this certification within this 1.5% corridor.

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 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).

[1] https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx
[2] https://coronavirus.ohio.gov/wps/wcm/connect/gov/e7cee147-0f86-438b-ae1f-c5922f46c47c/Director%27s+Order+non-essential+surgery+3-17-2020.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-e7cee147-0f86-438b-ae1f-c5922f46c47c-n6XVhxL

- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the CY 2020 managed care program rating period.
- 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" will be 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."[3]

SUMMARY OF METHODOLOGY

The methodology used in developing the amendment to the certified CY 2020 capitation rates for effective dates of July 1, 2020 through December 31, 2020 is outlined below.

Appendix 1 contains a summary of July 2020 MMC capitation rate changes.

Step 1: Base Experience

We used the projected claims data underlying the CY 2020 MMC capitation rates, as outlined in the Original certification, as base experience for developing the July 1, 2020 capitation rates. These projected claims costs are inclusive of all retrospective, prospective, trend, managed care efficiency, and other claims cost adjustments made to the data as outlined in the Original certification.

Step 2: Adjustments for prospective program and policy changes

The base experience is adjusted for known policy and program changes that are expected to be implemented in July through December 2020. Documentation of items requiring the calculation of adjustment factors is provided in this report. Adjustments were applied to the base experience data to reflect program changes not included in the Original certification. The resulting values establish the adjusted claim cost by population rate cell for the contract period.

Step 3: Incorporate non-claims items and adjustments

The adjusted claim cost is modified to include the impact of certain non-benefit items, such as an administrative allowance. Relative to the Original certification, we updated the per member per month (PMPM) add-on amounts attributable to the Enhanced Maternal Program and MCP Hospital Incentive after consideration of increases in enrollment projected to occur during CY 2020. Projected total expenditures included in the MMC capitation rates continue to equal $13.4 million and $162 million, respectively, for these two items. In addition, since the HIC Franchise Fee is assessed on a state fiscal year basis, this amendment reflects HIC Franchise Fee amounts applicable to July through December 2020. No other changes were made to non-claims assumptions from the values included in the Original certification.

Step 4: Development and issuance of actuarial certification

An actuarial certification is included and signed by Jeremy D. Palmer, FSA, a Principal and Consulting Actuary in the Indianapolis office of Milliman, Inc. Mr. Palmer meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, to certify that the final rates meet the standards in 42 CFR 438.4(a).

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

II. Prospective Data Adjustments

PROGRAM ADJUSTMENTS: JULY THROUGH DECEMBER 2020

Adjustment factors for the July 1, 2020 rate amendment were developed for the following policy and program changes, known as of the date of this report, that are anticipated to affect the MMC program during July through December 2020.

With the exception of nursing facility (NF) and other select services subject to 438.6(c) preprints approved by CMS, MCP provider contracts are not required to equal the Medicaid fee schedule. However, data available in MCP surveys indicate that a large portion of reimbursement is tied to Medicaid fee-for-service (FFS). MCPs are notified of program and reimbursement changes that will be reflected in future rate setting activities and are provided the opportunity to share comments and feedback. The reimbursement changes reflected in the July amendment to the CY 2020 capitation rates were determined to be reasonably achievable by the MCPs.

Nursing Facility Per Diem Rates

ODM updates NF payment rates and acuity scores on a semi-annual basis. We applied adjustments for the semi-annual per diem rate change that will occur beginning July 1, 2020. Adjustments were applied to the nursing facility category of service and vary based on differences in projected nursing facility experience by rate cell and region.

Ventilator-Dependent Nursing Facility Rate Change

Effective July 1, 2020 ODM will increase its nursing facility payment rate to $972.46 for individuals who are ventilator-dependent and $1,166.95 for individuals who are weaning off ventilator dependence. We estimated the impact of this policy change by repricing the average July 2020 projected NF per diem rate to the ventilator-dependent per diem rates for individuals identified as either ventilator-dependent or weaning off ventilator dependence.

Non-Facility Reimbursement Changes

We reviewed the impact of other non-facility reimbursement changes effective after January 1, 2020 that were not already incorporated into the Original certification. This included reimbursement changes to durable medical equipment (DME), Rad/Path/Lab, immunizations/injections, and other physician services. 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.

Impact of Increased Caseload

On January 31, 2020, the Secretary of Health and Human Services (HHS) declared a public health emergency under section 319 of the Public Health Service Act (42 U.S.C. 247d), in response to COVID-19. Beginning in March 2020, ODM paused the member redetermination process to ensure members do not lose coverage while in the midst of the pandemic. We anticipate members will continue to not be dis-enrolled through September 2020, resulting in a material increase to the MMC caseload. Simultaneously, ODM projects the enrollee caseload to further increase due to higher unemployment rates during the remainder of CY 2020, particularly for the Covered Families and Children (CFC) and Extension populations. To estimate the caseload increase, we relied on enrollment forecasts provided by ODM. In addition, we used historical churn rates in the MMC program to estimate the portion of enrollment growth attributable to the pause in redetermination versus new enrollees.

The following outlines our methodology for estimating the relative morbidity of the projected caseload increase during the July through December 2020 time period.

- **Historically Medicaid enrollees.** To estimate the morbidity of members who would have otherwise dis-enrolled, as well as new enrollees who were previously enrolled in Medicaid, we summarized CY 2018 base period experience for those who had dis-enrolled through July 2019 and compared their claims cost to the CY 2018 composite base experience. Based on this analysis, we developed and applied separate morbidity factors by rate cell and major service category.

- **New to Medicaid enrollees.** As a result of the COVID-19 pandemic, it is assumed that an increased number of individuals will become eligible for Medicaid as a result of lost employment. We anticipate that a portion of these newly MMC eligible individuals will have a cost profile that more closely resembles those observed in the employer sponsored insurance (ESI) market rather those in Medicaid. In projecting the relative morbidity of these members, we primarily relied upon a combination of American Community Survey (ACS) and Current Population Survey (CPS) data to develop an assumed distribution of covered members by self-reported health status (Excellent, Very Good, Good, Fair, and Poor) for the Medicaid and ESI markets. Coupled with relative morbidity assumptions by health status, which we developed using July 1, 2018 through June 30, 2019 MMC experience along with the survey data, we developed a comparison of the morbidity of a typical ESI enrollee versus a Medicaid enrollee.

We estimated the impact of the increased caseload in composite by combining the caseload increase attributable to each of the above cohorts along with relative morbidity for each cohort. For the HST 19-64 F pregnant women rate cell, we modeled the projected impact of members no longer exiting the rate cell shortly after delivery. We summarized historic data by members' proximity before or after their most recent delivery to develop estimated cost differences. We forecasted the HST 19-64 F rate cell for the July through December 2020 rating period assuming members continue to be enrolled in the rate cell following delivery, resulting in a greater percentage of member months for members who have already given birth.

Immaterial Program Adjustments

Adjustment factors were developed for policy and program changes estimated to ***materially*** affect the managed care program during July through December 2020 that were not reflected in the Original Certification. Program adjustments were applied in the rate development process to the extent a policy or reimbursement change is deemed to have a material cost impact to the MCPs. *We defined a program adjustment to be 'material' if the total benefit expense for any individual rate cell is impacted by more than 0.1%, or if the program adjustment was considered 'material' for the MyCare Ohio program.* The following program adjustments were deemed immaterial based on our review of the policy change.

- **Lifting of Hepatitis C Sobriety Requirement.** Effective April 1, 2020, ODM lifted the sobriety requirement for members seeking access to high-cost Hepatitis C drugs. We reviewed data provided by ODM which summarized Hepatitis C patient denials during Q4 2019, including those that were denied either partially or solely due to the sobriety requirement. In recognition of this program change, we evaluated the Hepatitis C risk pool PMPM amounts and determined that updated projected expenditures were reasonable relative to the Original certification.

- **Nursing Facility Bed Hold Days.** ODM anticipates increasing the number of nursing facility bed-hold days from 30 days to 60 days. These days represent the length of time that a NF provider is expected to reserve a bed for NF residents while the resident is temporarily absent from the NF for hospitalization. Based on our review of the bed-hold days in the baseline experience data, we believe that this change is immaterial to the MMC program.

III. Non-Benefit Expenses

ADMINISTRATIVE EXPENSE COST ALLOWANCE

The development of the actuarially sound capitation rates for July 2020 includes non-benefit expense assumptions consistent with the values included in the Original certification. In addition, the July amendment to the CY 2020 capitation rates includes amounts for the following non-benefit expenses:

Enhanced Maternal Program: ODM has implemented an enhanced maternal health program to target geographic areas with high infant mortality rates. A total of $6.5 million was added to four female CFC rate cells, before fees and taxes, for the enhanced maternal program for the July through December 2020 time period. The rate cells assumed to be included in the program are HF/HST 14-18 F, HF 19-44 F, HF 45+ M+F, and HST 19-64 F. The total dollar amount of available funding for the enhanced maternal program was allocated based on the assumed percent of targeted membership in each region and rate cell, consistent with the Original certification.

MCP Hospital Incentive: The total computable funding for the MCP Hospital Incentive program is appropriated by Ohio's General Assembly from the State's General Revenue Fund. For CY 2020, the amount is assumed to be $162 million, excluding additional taxes and fees that are applied to the appropriation amount. Based on changes from the Original certification with regard to observed and projected enrollment in CY 2020, we estimated revised PMPM amounts for July through December 2020 such that composite projected payments would continue to equal $162 million.

HUB Contracting Requirements: Consistent with the Original certification, we included care management amounts under the DKP in six regions to account for the HUB contracting requirements.

STATE TAXES AND FEES

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 MCP based on projected Medicaid member months for July through December 2020, and then weighted based on regional enrollment by MCP. As the HIC Franchise Fee is assessed on a state fiscal year basis, the July Amendment to the CY 2020 capitation rates reflects HIC Franchise Fee amounts applicable to July through December 2020.

Beginning in February 2020, members in the South Central and Southeast regions who were enrolled with Paramount began to transition to other MCPs. As of July 2020, all members will have enrolled with other MCPs. We relied on member-level files provided by ODM to apportion these members to the appropriate MCPs.

The HIC tax will remain at 1% of total capitation.

HEALTH INSURANCE PROVIDERS FEE (HIF)

In the Original certification, we anticipated the capitation rates would be adjusted based on HIF amounts collected in CY 2021 that are attributable to 2020 net premiums. As of this rate amendment, we no longer expect to adjust the capitation rates for HIF amounts collected in CY 2021. U.S. House legislation "Further Consolidated Appropriations Act, 2020" repealed the HIF for calendar years beginning after December 31, 2020[4].

[4] https://docs.house.gov/billsthisweek/20191216/BILLS-116HR1865SA-RCP116-44.PDF

IV. Other Items

HEPATITIS C RISK POOL

As a result of the uncertainty associated with Hepatitis C pharmaceutical expenditures, the July 2020 rate structure will maintain a high risk pool for expenditures related to Hepatitis C prescription drugs. Relative to the Original certification, estimated Hepatitis C amounts on a PMPM basis were updated to reflect the increased caseload morbidity adjustments. Projected Hepatitis C risk pool expenditures have been updated to reflect projected enrollment for July through December 2020.

The expected timeline for reconciliation of the risk pool is consistent with the Original certification.

INCENTIVES AND WITHHOLDS

Effective April 1, 2018, ODM implemented a quality withhold arrangement for the MMC program. The withhold arrangement is measured on a calendar year basis. ODM is evaluating the withhold measures in the context of the COVID-19 pandemic and will apply adjustments as appropriate. Based on our discussions with ODM related to this process, we believe that the withhold will remain reasonably achievable by the MCPs.

MEDICAL LOSS RATIO

The capitation rates were developed such that the MCPs 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. ODM's provider agreement indicates that ODM will perform medical loss ratio (MLR) calculations for the MMC program. ODM has implemented a minimum MLR requirement of 86% for the MMC program. ODM will require remittance in the event an MCP reports an MLR below 86%.

V. Risk Adjustment

The July 1, 2020 through December 31, 2020 rate period will initially be risk adjusted based on a methodology that utilizes the most recent available data and concurrent disease weights. The risk adjustment diagnosis data will exclude diagnosis codes associated with diagnostic testing and certain medical supply codes. The MMC program will be risk adjusted using CDPS+Rx risk scoring models. Risk adjustment is performed on a budget neutral basis at the region and rate cell level. Newborns, one-year-olds, and delivery kick payments will be excluded from the risk adjustment process.

Along with HIC Franchise Fee and tax amounts, CICIP amounts included in the certification will be excluded from the risk adjustment process. Risk scores will be applied to the July 2020 capitation rates less these amounts. We will then apply CICIP amounts along with MCP-specific HIC Franchise Fee and tax amounts to the normalized rates on a budget neutral basis.

Following the completion of the rating period, we anticipate revising the initial July 2020 risk adjusted rates to utilize relative risk scores derived from an updated concurrent risk adjustment analysis. This methodology is being implemented as a result of changes in the auto-assignment process utilized in the MMC program, which has the potential to produce discrepancies in the risk profile by MCP for members not scored under the initial risk adjustment methodology.

None of these items represent a change from the risk adjustment methodology described in the Original certification.

VI. Limitations and Data Reliance

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the July 1, 2020 amendment to the certified calendar year (CY) 2020 capitation rates for the Medicaid Managed Care Program (MMC). The data and information presented may not be appropriate for any other purpose.

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

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

Milliman has relied upon certain data and information provided by ODM and the participating Medicaid MCPs in the development of the July 1, 2020 amendment to the certified CY 2020 capitation rates. Milliman has relied upon ODM and the MCPs for the accuracy of the data and accept it without audit. To the extent that the data provided is not accurate, the capitation rate development may 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.

At the time of this report, we acknowledge there is substantial uncertainty regarding the impact of the COVID-19 pandemic on future projections. It is possible that the COVID-19 pandemic could have a material impact on the capitation rates presented in this report. With the exception of the morbidity impact of increased caseload expected to be enrolled in July through December 2020, the impact of COVID-19 has been excluded from this analysis.

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: July 2020 Rate Change Summaries

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective July 1, 2020
July 2020 Rate Change Summary

Region: North Central

Rate Cell	Average Monthly Enrollment / Deliveries	Calendar Year 2020 Capitation Rate	July 2020 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	4,779	$ 1,023.28	$ 1,031.60	0.8%
HF/HST 1 M+F	4,200	192.11	199.21	3.7%
HF/HST 2-13 M+F	49,823	178.83	181.45	1.5%
HF/HST 14-18 M	7,870	235.22	238.09	1.2%
HF/HST 14-18 F	7,969	304.85	306.11	0.4%
HF 19-44 M	6,189	427.78	409.99	(4.2%)
HF 19-44 F	21,343	577.38	565.45	(2.1%)
HF 45+ M+F	3,356	897.67	872.26	(2.8%)
HST 19-64 F	1,285	826.07	740.91	(10.3%)
Subtotal CFC	**106,814**	**$ 355.12**	**$ 352.06**	**(0.9%)**
Extension				
EXT 19-34 M	8,560	$ 624.90	$ 593.85	(5.0%)
EXT 19-34 F	8,358	591.81	566.81	(4.2%)
EXT 35-44 M	4,161	907.14	865.11	(4.6%)
EXT 35-44 F	3,922	993.14	951.14	(4.2%)
EXT 45-54 M	4,107	1,057.64	1,009.02	(4.6%)
EXT 45-54 F	4,493	1,043.51	999.85	(4.2%)
EXT 55-64 M	3,826	1,178.91	1,134.78	(3.7%)
EXT 55-64 F	4,277	1,145.34	1,105.30	(3.5%)
Subtotal EXT	**41,705**	**$ 872.98**	**$ 835.81**	**(4.3%)**
ABD				
ABD <21	3,897	$ 851.86	$ 859.57	0.9%
ABD 21+	10,631	1,821.16	1,822.30	0.1%
Subtotal ABD	**14,528**	**$ 1,561.15**	**$ 1,564.05**	**0.2%**
AFK	**2,255**	**$ 573.24**	**$ 580.03**	**1.2%**
CFC & EXT Delivery	**304**	**$ 6,226.12**	**$ 6,226.12**	**0.0%**
Total	**165,301**	**$ 606.20**	**$ 595.19**	**(1.8%)**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective July 1, 2020
July 2020 Rate Change Summary

Region: Northwest

Rate Cell	Average Monthly Enrollment / Deliveries	Calendar Year 2020 Capitation Rate	July 2020 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	3,342	$ 871.70	$ 880.76	1.0%
HF/HST 1 M+F	2,901	180.98	186.81	3.2%
HF/HST 2-13 M+F	33,461	153.00	155.20	1.4%
HF/HST 14-18 M	5,403	263.16	264.11	0.4%
HF/HST 14-18 F	5,544	256.55	257.95	0.5%
HF 19-44 M	4,098	403.01	385.55	(4.3%)
HF 19-44 F	12,497	514.15	503.57	(2.1%)
HF 45+ M+F	1,992	862.44	837.72	(2.9%)
HST 19-64 F	1,014	586.33	529.42	(9.7%)
Subtotal CFC	**70,252**	**$ 310.19**	**$ 307.67**	**(0.8%)**
Extension				
EXT 19-34 M	4,325	$ 638.82	$ 606.56	(5.0%)
EXT 19-34 F	5,074	552.52	528.33	(4.4%)
EXT 35-44 M	2,354	794.95	758.47	(4.6%)
EXT 35-44 F	2,551	814.66	780.80	(4.2%)
EXT 45-54 M	2,274	1,071.22	1,018.46	(4.9%)
EXT 45-54 F	2,844	1,130.75	1,081.99	(4.3%)
EXT 55-64 M	2,266	1,284.29	1,233.93	(3.9%)
EXT 55-64 F	2,752	1,082.93	1,045.28	(3.5%)
Subtotal EXT	**24,439**	**$ 861.62**	**$ 824.35**	**(4.3%)**
ABD				
ABD <21	1,668	$ 814.06	$ 819.88	0.7%
ABD 21+	4,580	1,632.09	1,633.30	0.1%
Subtotal ABD	**6,247**	**$ 1,413.75**	**$ 1,416.19**	**0.2%**
AFK	**1,083**	**$ 608.93**	**$ 614.38**	**0.9%**
CFC & EXT Delivery	**187**	**$ 5,719.85**	**$ 5,719.85**	**0.0%**
Total	**102,021**	**$ 523.51**	**$ 513.05**	**(2.0%)**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective July 1, 2020
July 2020 Rate Change Summary

Region: Southwest

Rate Cell	Average Monthly Enrollment / Deliveries	Calendar Year 2020 Capitation Rate	July 2020 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	18,540	$ 1,202.89	$ 1,207.81	0.4%
HF/HST 1 M+F	16,608	240.65	243.66	1.3%
HF/HST 2-13 M+F	193,305	192.88	190.89	(1.0%)
HF/HST 14-18 M	29,917	257.45	255.31	(0.8%)
HF/HST 14-18 F	31,001	311.00	307.83	(1.0%)
HF 19-44 M	22,152	400.38	379.44	(5.2%)
HF 19-44 F	76,386	529.76	515.57	(2.7%)
HF 45+ M+F	12,545	780.18	755.00	(3.2%)
HST 19-64 F	4,958	743.93	669.93	(9.9%)
Subtotal CFC	**405,413**	**$ 354.55**	**$ 348.05**	**(1.8%)**
Extension				
EXT 19-34 M	31,931	$ 578.67	$ 546.29	(5.6%)
EXT 19-34 F	30,900	583.14	554.61	(4.9%)
EXT 35-44 M	17,533	796.19	756.22	(5.0%)
EXT 35-44 F	15,565	864.65	825.15	(4.6%)
EXT 45-54 M	16,114	1,012.54	960.10	(5.2%)
EXT 45-54 F	17,024	1,066.21	1,017.32	(4.6%)
EXT 55-64 M	14,711	1,187.94	1,139.20	(4.1%)
EXT 55-64 F	16,269	1,108.08	1,067.28	(3.7%)
Subtotal EXT	**160,047**	**$ 836.53**	**$ 797.24**	**(4.7%)**
ABD				
ABD <21	12,450	$ 1,125.95	$ 1,129.43	0.3%
ABD 21+	33,847	1,725.47	1,723.18	(0.1%)
Subtotal ABD	**46,297**	**$ 1,564.25**	**$ 1,563.51**	**(0.0%)**
AFK	**9,326**	**$ 772.64**	**$ 775.08**	**0.3%**
CFC & EXT Delivery	**1,112**	**$ 5,953.57**	**$ 5,953.57**	**0.0%**
Total	**621,082**	**$ 585.86**	**$ 571.47**	**(2.5%)**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective July 1, 2020
July 2020 Rate Change Summary

Region: South Central

Rate Cell	Average Monthly Enrollment / Deliveries	Calendar Year 2020 Capitation Rate	July 2020 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	15,710	$ 1,475.83	$ 1,482.60	0.5%
HF/HST 1 M+F	14,208	262.42	264.82	0.9%
HF/HST 2-13 M+F	166,896	197.56	195.74	(0.9%)
HF/HST 14-18 M	25,723	269.80	267.74	(0.8%)
HF/HST 14-18 F	26,119	335.97	332.70	(1.0%)
HF 19-44 M	21,432	405.72	385.44	(5.0%)
HF 19-44 F	61,624	600.34	584.40	(2.7%)
HF 45+ M+F	12,378	795.65	771.01	(3.1%)
HST 19-64 F	4,044	751.06	677.40	(9.8%)
Subtotal CFC	**348,133**	**$ 385.42**	**$ 378.75**	**(1.7%)**
Extension				
EXT 19-34 M	25,789	$ 670.37	$ 632.64	(5.6%)
EXT 19-34 F	25,111	659.17	626.69	(4.9%)
EXT 35-44 M	13,599	980.70	931.04	(5.1%)
EXT 35-44 F	12,554	966.49	922.92	(4.5%)
EXT 45-54 M	12,821	1,201.03	1,138.65	(5.2%)
EXT 45-54 F	13,713	1,111.36	1,061.06	(4.5%)
EXT 55-64 M	10,752	1,351.68	1,296.19	(4.1%)
EXT 55-64 F	12,264	1,208.12	1,161.72	(3.8%)
Subtotal EXT	**126,603**	**$ 942.31**	**$ 897.55**	**(4.7%)**
ABD				
ABD <21	9,712	$ 1,203.28	$ 1,207.20	0.3%
ABD 21+	30,651	1,814.90	1,813.17	(0.1%)
Subtotal ABD	**40,364**	**$ 1,667.73**	**$ 1,667.36**	**(0.0%)**
AFK	**7,042**	**$ 778.11**	**$ 781.31**	**0.4%**
CFC & EXT Delivery	**955**	**$ 5,768.18**	**$ 5,768.18**	**0.0%**
Total	**522,141**	**$ 635.42**	**$ 620.13**	**(2.4%)**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective July 1, 2020
July 2020 Rate Change Summary

Region: Southeast

Rate Cell	Average Monthly Enrollment / Deliveries	Calendar Year 2020 Capitation Rate	July 2020 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	5,014	$ 1,190.27	$ 1,194.97	0.4%
HF/HST 1 M+F	4,473	261.24	264.74	1.3%
HF/HST 2-13 M+F	54,654	190.72	189.56	(0.6%)
HF/HST 14-18 M	9,176	275.22	273.38	(0.7%)
HF/HST 14-18 F	9,302	317.92	315.78	(0.7%)
HF 19-44 M	8,950	442.05	419.18	(5.2%)
HF 19-44 F	22,848	562.21	547.87	(2.6%)
HF 45+ M+F	4,142	844.10	817.04	(3.2%)
HST 19-64 F	1,494	693.20	621.57	(10.3%)
Subtotal CFC	**120,051**	**$ 369.64**	**$ 362.87**	**(1.8%)**
Extension				
EXT 19-34 M	9,955	$ 587.28	$ 554.77	(5.5%)
EXT 19-34 F	9,543	593.60	565.16	(4.8%)
EXT 35-44 M	5,316	772.44	735.83	(4.7%)
EXT 35-44 F	5,045	871.15	832.72	(4.4%)
EXT 45-54 M	5,151	1,012.96	961.77	(5.1%)
EXT 45-54 F	5,941	1,000.44	956.17	(4.4%)
EXT 55-64 M	4,891	1,196.43	1,148.53	(4.0%)
EXT 55-64 F	5,695	1,128.96	1,086.82	(3.7%)
Subtotal EXT	**51,537**	**$ 843.18**	**$ 804.67**	**(4.6%)**
ABD				
ABD <21	3,116	$ 1,136.21	$ 1,141.11	0.4%
ABD 21+	12,168	1,603.59	1,602.22	(0.1%)
Subtotal ABD	**15,283**	**$ 1,508.31**	**$ 1,508.22**	**(0.0%)**
AFK	**3,025**	**$ 798.95**	**$ 803.30**	**0.5%**
CFC & EXT Delivery	**316**	**$ 5,001.74**	**$ 5,002.01**	**0.0%**
Total	**189,896**	**$ 604.96**	**$ 590.30**	**(2.4%)**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective July 1, 2020
July 2020 Rate Change Summary

Region: Northeast

Rate Cell	Average Monthly Enrollment / Deliveries	Calendar Year 2020 Capitation Rate	July 2020 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	20,391	$ 1,308.30	$ 1,309.35	0.1%
HF/HST 1 M+F	18,714	245.23	248.29	1.2%
HF/HST 2-13 M+F	229,076	199.81	198.15	(0.8%)
HF/HST 14-18 M	37,192	253.24	251.86	(0.5%)
HF/HST 14-18 F	38,584	302.54	300.33	(0.7%)
HF 19-44 M	30,284	363.38	345.89	(4.8%)
HF 19-44 F	100,984	519.68	506.81	(2.5%)
HF 45+ M+F	18,885	738.70	716.49	(3.0%)
HST 19-64 F	5,149	823.87	740.51	(10.1%)
Subtotal CFC	**499,259**	**$ 360.15**	**$ 353.90**	**(1.7%)**
Extension				
EXT 19-34 M	49,370	$ 538.47	$ 509.69	(5.3%)
EXT 19-34 F	45,315	531.19	506.54	(4.6%)
EXT 35-44 M	24,482	725.21	690.08	(4.8%)
EXT 35-44 F	21,055	752.76	719.99	(4.4%)
EXT 45-54 M	24,253	954.82	907.20	(5.0%)
EXT 45-54 F	25,228	962.73	920.25	(4.4%)
EXT 55-64 M	23,518	1,120.57	1,076.68	(3.9%)
EXT 55-64 F	26,356	987.06	950.91	(3.7%)
Subtotal EXT	**239,578**	**$ 768.32**	**$ 733.68**	**(4.5%)**
ABD				
ABD <21	17,881	$ 1,069.38	$ 1,073.55	0.4%
ABD 21+	51,605	1,712.51	1,713.42	0.1%
Subtotal ABD	**69,486**	**$ 1,547.01**	**$ 1,548.76**	**0.1%**
AFK	**9,890**	**$ 749.74**	**$ 752.78**	**0.4%**
CFC & EXT Delivery	**1,288**	**$ 6,110.76**	**$ 6,110.76**	**0.0%**
Total	**818,213**	**$ 594.78**	**$ 581.02**	**(2.3%)**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective July 1, 2020
July 2020 Rate Change Summary

Region: Northeast Central

Rate Cell	Average Monthly Enrollment / Deliveries	Calendar Year 2020 Capitation Rate	July 2020 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	5,264	$ 978.15	$ 982.35	0.4%
HF/HST 1 M+F	4,589	216.86	220.51	1.7%
HF/HST 2-13 M+F	54,515	181.13	180.39	(0.4%)
HF/HST 14-18 M	8,562	242.26	241.45	(0.3%)
HF/HST 14-18 F	8,878	291.79	289.86	(0.7%)
HF 19-44 M	6,892	392.86	373.57	(4.9%)
HF 19-44 F	22,074	490.54	478.32	(2.5%)
HF 45+ M+F	3,521	720.43	698.14	(3.1%)
HST 19-64 F	1,498	632.94	566.47	(10.5%)
Subtotal CFC	**115,793**	**$ 325.61**	**$ 320.38**	**(1.6%)**
Extension				
EXT 19-34 M	8,517	$ 554.21	$ 524.13	(5.4%)
EXT 19-34 F	9,179	530.38	505.43	(4.7%)
EXT 35-44 M	4,520	740.77	704.66	(4.9%)
EXT 35-44 F	4,703	805.78	769.75	(4.5%)
EXT 45-54 M	4,496	930.40	883.60	(5.0%)
EXT 45-54 F	5,235	943.49	901.98	(4.4%)
EXT 55-64 M	4,337	1,154.40	1,107.24	(4.1%)
EXT 55-64 F	5,270	998.07	960.08	(3.8%)
Subtotal EXT	**46,255**	**$ 780.75**	**$ 745.07**	**(4.6%)**
ABD				
ABD <21	3,374	$ 1,145.96	$ 1,150.70	0.4%
ABD 21+	9,138	1,539.66	1,538.52	(0.1%)
Subtotal ABD	**12,511**	**$ 1,433.49**	**$ 1,433.94**	**0.0%**
AFK	**2,492**	**$ 632.70**	**$ 636.17**	**0.5%**
CFC & EXT Delivery	**308**	**$ 5,090.07**	**$ 5,090.07**	**0.0%**
Total	**177,051**	**$ 535.99**	**$ 523.32**	**(2.4%)**

Ohio Department of Medicaid
Medicaid Managed Care Program
Capitation Rates Effective July 1, 2020
July 2020 Rate Change Summary

Region: Statewide

Rate Cell	Average Monthly Enrollment / Deliveries	Calendar Year 2020 Capitation Rate	July 2020 Capitation Rate	% Change
CFC				
HF/HST <1 M+F	73,040	$ 1,247.06	$ 1,251.64	0.4%
HF/HST 1 M+F	65,692	240.66	244.02	1.4%
HF/HST 2-13 M+F	781,730	192.34	191.10	(0.6%)
HF/HST 14-18 M	123,842	257.85	256.53	(0.5%)
HF/HST 14-18 F	127,397	309.97	307.71	(0.7%)
HF 19-44 M	99,996	395.33	375.86	(4.9%)
HF 19-44 F	317,756	542.44	528.75	(2.5%)
HF 45+ M+F	56,818	780.54	756.51	(3.1%)
HST 19-64 F	19,442	751.34	675.85	(10.0%)
Subtotal CFC	**1,665,713**	**$ 359.92**	**$ 353.92**	**(1.7%)**
Extension				
EXT 19-34 M	138,447	$ 585.27	$ 553.39	(5.4%)
EXT 19-34 F	133,480	576.31	548.99	(4.7%)
EXT 35-44 M	71,964	808.05	768.38	(4.9%)
EXT 35-44 F	65,394	850.20	812.49	(4.4%)
EXT 45-54 M	69,215	1,026.53	974.61	(5.1%)
EXT 45-54 F	74,477	1,026.69	980.92	(4.5%)
EXT 55-64 M	64,302	1,191.92	1,144.21	(4.0%)
EXT 55-64 F	72,884	1,076.06	1,036.27	(3.7%)
Subtotal EXT	**690,164**	**$ 832.11**	**$ 793.93**	**(4.6%)**
ABD				
ABD <21	52,097	$ 1,092.37	$ 1,096.73	0.4%
ABD 21+	152,619	1,722.07	1,721.46	(0.0%)
Subtotal ABD	**204,716**	**$ 1,561.82**	**$ 1,562.48**	**0.0%**
AFK	**35,112**	**$ 741.77**	**$ 745.14**	**0.5%**
CFC & EXT Delivery	**4,470**	**$ 5,841.17**	**$ 5,841.19**	**0.0%**
Total	**2,595,705**	**$ 595.48**	**$ 581.58**	**(2.3%)**

APPENDIX F

MARKETING AND MEMBER COMMUNICATIONS

The following are the MCP responsibilities related to communicating with eligible individuals pre-enrollment and MCP members post-enrollment. Upon request, the MCP shall provide both members and eligible individuals with a copy of their practice guidelines.

1. **Marketing Activities.** Marketing means any communication from the MCP to an eligible individual who is not a member of the MCP that can reasonably be interpreted as intended to influence the individual to select membership in the MCP, or to not select membership in or to terminate membership from another MCP. When marketing, the MCP shall:

    a. Ensure representatives, as well as materials and plans, represent the MCP 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, door-to-door or telephone contact. Cold-call marketing means any unsolicited personal contact by the MCP with an eligible individual for the purpose of marketing.

    d. Receive prior approval for any event or location where the MCP 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 MCP 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 MCP 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 MCP.

    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 the MCP'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 MCP prior to making an MCP membership selection, and the process for contacting ODM to select an MCP.

ii. Information that membership in the particular MCP is voluntary and that a decision to select or not select the MCP 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 MCP's member handbook and provider directory. Upon request, the MCP 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 MCP, will be available to all members.

k. 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 MCPs, as all enrollment activities shall be completed by the Hotline.

2. **Marketing Representatives and Training.** An MCP 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 MCP. 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 MCP 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 MCP 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 MCP'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 MCP'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 MCP'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 MCP and the marketing representatives if ODM rules are violated.

6. Review of the MCP's code of conduct or ethics.

ii. Methods that the MCP will utilize to determine initial and ongoing competency with the training curriculum.

e. Any MCP staff person providing MCP 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 that the staff person is not mistaken for an Ohio Medicaid Consumer Hotline, federal, state, or county employee.

ii. Inform eligible individuals that the following MCP 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 MCP'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 MCP 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 MCP membership in a particular MCP. As provided in ORC Chapter 1751 and ORC section 3905.01, all non-licensed agents, including providers, are prohibited from

advising or recommending to an eligible individual that he or she select MCP membership in a particular MCP as this would constitute the unlicensed practice of marketing.

g. MCP informational displays do not require the presence of a marketing representative if no marketing presentation will be made.

3. **Marketing Materials.** Marketing materials are those items produced in any medium, by or on behalf of the MCP, including gifts of nominal value (i.e., items worth no more than $15.00), which can reasonably be interpreted as intended to market to eligible individuals as defined in OAC rule 5160-26-01.

   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 MCP 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 MCP's entire service area.

      v. The mailing and distribution of all MCP 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 MCP 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 MCP's request, mail MCP marketing materials to the eligible individuals. Postage and handling for each mailing will be charged to the requesting MCP. The MCP address shall not be used as the return address in mailings to eligible individuals processed by ODM.

   c. **Solicitation Brochure**. The MCP shall have a solicitation brochure available to eligible individuals which contains, at a minimum:

      i. Identification of the Medicaid recipients eligible for the MCP's coverage.

      ii. Information that the MCP'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 MCP is voluntary, that a decision to select MCP membership or to not select MCP membership in the MCP will not affect eligibility for Medicaid or other public assistance benefits, and that individuals may change MCPs under certain circumstances.

vi. Information on how the individual can request or access additional MCP 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 MCP's service area; or

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 MCP operates will be provided upon request.

ix. Information that the individual shall choose a PCP from the MCP's provider panel and that 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 MCP'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 information that access to emergency services is available within and outside the service area.

xiii. A description of the MCP's policies regarding access to providers outside the service area.

xiv. Information on member-initiated termination options in accordance with OAC rule 5160-26-02.1.

xv. Information on the procedures an eligible individual shall follow to select membership in an MCP including any applicable ODM selection requirements.

xvi. If applicable, information on any member co-payments the MCP has elected to implement in accordance with OAC rule 5160-26-12.

4. **Marketing Plan.** The MCP shall submit an annual marketing plan to ODM that includes all planned activities for promoting membership in or increasing awareness of the MCP. The marketing plan submission shall include an attestation by the MCP that the plan is accurate is not intended to mislead, confuse or defraud the eligible individuals or ODM.

5. **ODM Approval.** The MCP 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 MCP 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 on the review process for MCP submitted marketing materials.

6. **Alleged Marketing Violations.** The MCP 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.

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

8. **Member Materials.** Member materials are those items developed by or on behalf of the MCP to fulfill MCP 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 MCP and which do not include any reference to the MCP 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 OAC rule 5160-26-05.1.

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

9. **New Member Materials.** The MCP shall provide to each member or assistance group that selects or changes MCPs an MCP identification (ID) card, a new member letter, notice of advanced directives, provider directory postcard, and post card providing the link to the member handbook, if sent in lieu of the full member handbook.

a. **ID Card.** The MCP ID card shall contain:

i. The MCP's name as stated in its article of incorporation and any other trade or DBA name used;

ii. The name of the member(s) enrolled in the MCP and each member's medical management information system billing number;

iii. The name and telephone numbers of the PCPs assigned to the members;

iv. Information on how to obtain the current eligibility status of the members;

v. Coordinated Services Program (CSP) information as specified by ODM;

vi. Pharmacy information; and

vii. The MCP's emergency procedures including the toll-free call-in system phone numbers.

b. **New Member Letter**. The MCP shall use the model language specified by ODM for the new member letter and member handbooks. The MCP New Member Letter shall inform each member of the following:

i. The new member materials issued by the MCP, what action to take if he or she did not receive those materials, and how to access the MCP's provider directory;

ii. How to access MCP-provided transportation services;

iii. How to change primary care providers;

iv. The population groups not required to select MCP membership and what action to take if a member believes he or she meets this criteria and does not want to be an MCP member;

v. The need and time frame for a member to contact the MCP if he or she has a health condition that the MCP should be aware of in order to most appropriately manage or transition the member's care; and

vi. The need and how to access information on medications that require prior authorization.

c. **Member Handbook**. The MCP Member Handbook shall be clearly labeled as such and shall include:

i. The rights of members including all rights found in OAC rule 5160-26-08.3 and any member responsibilities specified by the MCP. With the exception of any prior authorization (PA) requirements the MCP describes in the member handbook, the MCP cannot establish any member responsibility that would preclude the MCP's coverage of a Medicaid-covered service.

ii. Information regarding services excluded from MCP coverage and the services and benefits available through the MCP and how to obtain them, including at a minimum:

1. All services and benefits requiring PA or referral by the MCP or the member's PCP;

2. 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;

3. FQHC, RHC, and certified nurse practitioner services specified in OAC rule 5160-26-03; and

4. Any applicable pharmacy utilization management strategies prior-approved by ODM.

iii. Information regarding available emergency services, the procedures for accessing emergency services and directives as to the appropriate utilization, including:

1. An explanation of the terms "emergency medical condition," "emergency services," and "post-stabilization services," as defined in OAC rule 5160-26-01;

2. A statement that PA is not required for emergency services;

3. An explanation of the availability of the 911 telephone system or its local equivalent;

4. A statement that members have the right to use any hospital or other appropriate setting for emergency services; and

5. An explanation of the post-stabilization care services requirements specified in OAC rule 5160-26-03.

iv. The procedure for members to express their recommendations for change to the MCP;

v. Identification of the categories of Medicaid recipients eligible for MCP membership;

vi. Information stating that the MCP's ID card replaces the member's monthly Medicaid card, how often the card is issued, and how to use it;

vii. A statement that medically necessary health care services shall be obtained through the providers in the MCP's provider network with any exceptions that apply such as emergency care;

viii. Information related to the selection of a PCP from the MCP provider directory, how to change PCPs at least monthly, the MCP's procedures for processing PCP change requests after the initial month of MCP membership, and how the MCP will provide written confirmation to the member of any new PCP selection prior to or on the effective date of the change;

ix. A description of Healthchek services including who is eligible and how to obtain Healthchek services through the MCP;

x. Information on additional services available to members including care management;

xi. A description of the MCP'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;

xii. Information on member-initiated termination options in accordance with OAC rule 5160-26-02.1;

xiii. Information about MCP-initiated terminations;

xiv. An explanation of automatic MCP membership renewal in accordance with OAC rule 5160-26-02;

xv. The procedure for members to file an appeal, a grievance, or state hearing request as specified in OAC rule 5160-26-08.4, the MCP's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the MCP. Copies of the form(s) to file an appeal or grievance shall also be made available through the MCP's member services program;

xvi. The standard and expedited state hearing resolution time frames as outlined in 42 CFR 431.244;

xvii. The member handbook issuance date;

xviii. A statement that the MCP 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;

xix. An explanation of subrogation and coordination of benefits;

xx. A clear identification of corporate or parent identity when a trade name or DBA is used for the Medicaid product;

xxi. Information on the procedures for members to access behavioral health services;

xxii. Information on the MCP'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;

xxiii. A statement that the MCP provides covered services to members through a provider agreement with ODM, an10d how members can contact ODM;

xxiv. The toll-free call-in system phone numbers;

xxv. A statement that additional information is available from the MCP upon request including, at a minimum, the structure and operation of the MCP and any physician incentive plans the MCP operates;

xxvi. Process for requesting or accessing additional MCP information or services including at a minimum:

1. Oral interpretation or translation services;

2. Written information in the prevalent non-English languages in the MCP's service areas; and

3. Written information in alternative formats.

xxvii. If applicable, detailed information on any member co-payments the MCP has elected to implement in accordance with OAC rule 5160-26-12;

xxviii. How to access the MCP's provider directory; and

xxix. The MCP shall provide access to provider panel information to members via the MCP's website and printed provider directories.

d. In addition to an MCP identification (ID) card, a new member letter, and a member handbook, the MCP shall provide to each member or assistance group, as applicable, provider panel information, Notice of Nondiscrimination, and information on advance directives, as specified by ODM.

10. If a member's name, date of birth, or Medicaid identification number changes, the MCP shall issue a new ID card. The MCP shall also issue a new member handbook postcard to the member if the member handbook has been revised since the initial MCP membership date.

11. **Issuance of Member Materials**. The ID card, new member letter, and request postcard shall be mailed within 10 business days of receiving the 834C enrollment file, except during state cutoff when plans have the option to follow the 834 file loading process as specified by ODM.

    a. The MCP may mail ODM prior-approved postcards to new members in lieu of mailing printed advance directives, directories, and member handbooks. At a minimum, the postcards shall advise members to call the MCP or return the postcards to request a printed advance directive, provider directory, and/or member handbook.

    b. If the MCP does not use an ODM prior-approved postcard, the MCP shall mail printed advance directives, provider directories, and member handbooks to all new members, within 5 calendar days of receiving the 834C.

    c. If requested, a printed advance directive, provider directory, and member handbook shall be sent to a member within seven calendar days of the request.

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

    e. The MCP ID card shall contain pharmacy information, as prescribed by ODM.

12. **Information Required for MCP Websites.**

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

    b. **On-line Member Website**. The MCP 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 MCP's responses to questions or comments shall be made within one business day of receipt. The MCP's responses to grievances and appeals shall adhere to the timeframes specified in OAC rule 5160-26-08.4. 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 MCP information (e.g., change in holiday closures, changes in additional benefits, and revisions to approved member materials). The MCP shall make a copy of its Authorized Representative request form available to members through its online member portal located on the MCP's website.

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

ii. A listing of the counties the MCP serves or an indication that the MCP serves the entire state;

iii. The ODM-approved MCP member handbook, recent newsletters, and announcements;

iv. The MCP's on-line provider directory as referenced this appendix;

v. Current version of the Member Handbook;

vi. A list of services requiring prior authorization (PA);

vii. A link to the ODM Unified Preferred Drug List available at https://pharmacy.medicaid.ohio.gov/drug-coverage, including the MCP's list of drugs that require PA and how to initiate a PA. If applicable, the MCP may post a separate preferred drug list (PDL) for any drugs not included in the UPDL.

viii. A 30-calendar day's advance notice of changes to the list of all services requiring prior authorization The MCP shall provide a hard copy of the notification of any PA changes upon request;

ix. The toll-free telephone number for the 24/7 medical advice call-in system specified in Appendix C;

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

xi. The toll-free member services, 24/7 call-in systems, and transportation scheduling telephone numbers shall be easily identified on either the MCP's website home page or a page that is a direct link from a contact button on the home page. ODM may require the MCP to include additional information on the member website as needed; and

xii. All Healthchek information as specified Appendix C.

13. The MCP 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 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.** The MCP shall ensure members have timely access to all services outlined in OAC rule 5160-26-03 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 and in accordance with 42 CFR 438.210, with limited exclusions, limitations, and clarifications (specified in this appendix), including emergency and post-stabilization services pursuant to 42 CFR 438.114. For information on Medicaid-covered services, the MCP shall refer to the Ohio Department of Medicaid (ODM) website. Services covered by the MCP benefit package shall 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 Healthchek, Ohio's 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 discovered by a screening described in 42 U.S.C. 1396d(r). 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 also be provided by plans to children under the age of 21;

    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;

r. Vision care services, including eyeglasses;

s. Nursing facility stays as specified in OAC rule 5160-26-03 for ABD and MAGI members. For Adult Extension members, nursing facility stays are covered for the length of time medically necessary. ;

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 MCP 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. Respite services for Supplemental Security Income (SSI) members under the age of 21 with long-term care or behavioral health needs in accordance with OAC rule 5160-26-03;

aa. Telemedicine; and

bb. Services for members with a primary diagnosis of Autism Spectrum Disorder (ASD) including coverage mandated by ORC section 1751.84.

2. **Exclusions.** The MCP is not required to pay for services not covered by the Medicaid program, except as specified in OAC rule 5160-26-03 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 rule 5160-9-03;

    o. Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual. This does not pertain to withholding or withdrawing medical treatment, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death;

    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 consumers; and

q. Non-emergency services or supplies provided by out-of-network providers, unless the member has followed the instructions in the MCP member handbook for seeking coverage of such services, or unless otherwise directed by ODM.

3. Clarifications.

a. **Member Cost-Sharing.** As specified in OAC rules 5160-26-05 and 5160-26-12, the MCP is permitted to impose the applicable member co-payment amount for dental services, vision services, non-emergency emergency department services, or prescribed drugs, the MCP shall notify ODM if they intend to impose a co-payment. ODM shall approve the notice to be sent to the MCP's members and the timing of when the co-payments will begin to be imposed. If ODM determines the MCP's decision to impose a particular co-payment on their members would constitute a significant change for those members, ODM may require the effective date of the co-payment to coincide with the "Open Enrollment" month.

Notwithstanding the preceding paragraph, the MCP shall provide an ODM-approved notice to all their members 90 calendar days in advance of the date that the MCP will impose the co-payment. With the exception of member co-payments the MCP has elected to implement in accordance with OAC rules 5160-26-05 and 5160-26-12, the MCP's payment constitutes payment in full for any covered services and their subcontractors shall not charge members or ODM any additional co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise.

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 MCP shall verify that all of the information on the applicable required forms (ODM 03197, ODM 03199, HHS-687, and HHS-687-1 (SPANISH VERSION)) is provided and that the service meets the required criteria before any such claim is paid.

Additionally, payment 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 MCP is responsible for educating their providers on the requirements; implementing internal procedures including systems edits to ensure claims are only paid once the MCP has determined if the applicable forms are completed and the required criteria are met, as confirmed by the appropriate certification or consent forms; and for maintaining documentation to justify any such claim payments. If the MCP has made the determination that the requirements associated with an abortion, sterilization, or hysterectomy were sufficiently met by the provider, then no additional information (i.e. operative notes, history and physical, ultrasound) is required from ancillary providers.

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

d. **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.

e. **Institutions for Mental Disease (IMDs) for Mental Health Stays**. In accordance with 42 CFR 438.6(e), the MCP 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 MCP 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 MCP 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. MCP payments to the IMD are established in the plan's contractual agreement with the provider. The MCP is required to report quarterly on IMD stays that exceed 15 days per calendar month per ODM's specifications.

f. **Substance Use Disorder (SUD) Treatment.** The MCP will continue to work with ODM in development of the 1115 SUD demonstration waiver to provide services to individuals with an SUD diagnosis. The MCP 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 MCP must use the ASAM criteria in determining coverage for inpatient hospital services for individuals, however, the MCP must also use other clinical criteria (i.e. MCG or InterQual) and must authorize services when either criteria indicate inpatient services are necessary. The MCP 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.

g. **Urine Drug Screening**. The MCP shall abide by the urine drug screening guidelines for individuals with substance use disorder as specified by ODM.

h. **Organ Transplants.**

    i. The MCP shall ensure coverage for organ transplants and related services in accordance with OAC rule 5160-2-65. Coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium" based on criteria established by Ohio organ transplant surgeons and authorization from the ODM prior authorization unit. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC rule 3701-84-01, is contingent upon review and recommendation by the "Ohio

Hematopoietic Stem Cell Transplant Consortium" based on criteria established by Ohio experts in the field of bone marrow transplant and authorization from the ODM prior authorization unit. While the MCP may require prior authorization for these transplant services, the approval criteria shall be limited to confirming the member has been recommended to and approved for a transplant by either consortium and authorized by ODM. In accordance with OAC rule 5160-2-03, all services related to covered organ donations are covered for the donor recipient when the member is Medicaid eligible.

ii. **Prior Authorizations for Transplant Evaluations (Pre-Transplants).** The MCP is prohibited from requiring prior authorization that may create a barrier to accessing the "Ohio Solid Organ Transplant Consortium" or "Ohio Hematopoietic Stem Cell Transplant Consortium" for review and recommendation (e.g., a member shall be able to access pre-transplant services required for consortium review). The MCP may require providers to submit prior information for the purposes of assisting members with identifying available providers, initiating care management services, and addressing any compensation issues. However, when identifying available providers that could ultimately impact where the transplant is performed, the MCP shall not solely consider a provider's panel status but also consider the proximity to a member's residence, support system, and the network of providers who have coordinated the member's care.

i. **Acupuncture.** Ohio Medicaid acupuncture coverage, described in OAC rule 5160-8-51, is limited to the pain management of migraine headaches and lower back pain.

j. **Gender Transition.** Pursuant to 45 CFR 92.207(b)(4), the MCP is prohibited from having or implementing a categorical coverage exclusion or limitation for all health services related to gender transition. However, 45 CFR 92.207(d) clarifies that this does not prevent the MCP from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in individual cases.

k. **Hospice Services**. In accordance with 1905(o)(3)(C) and 1902(a)(32) of the Act, and 42 CFR 447.10, the MCP 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.

l. **Inpatient Hospital Services.** When billing inpatient hospital services, the MCP 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 MCP is required to share specific information with certain non-panel providers. The information is to assist non-panel providers to recognize MCP membership, access information needed to provide services, and, if applicable, successfully submit claims to the MCP.

a. **ODM-Designated Providers**. The MCP shall share specific information with MHA-certified CMHCs, MHA-certified Medicaid providers, FQHCs/RHCs, qualified family planning providers (QFPPs), hospitals, and if applicable, certified nurse midwives (CNMs), certified nurse practitioners (CNPs), and free-standing birth centers (FBCs) as defined in OAC rule 5160-18-01 within the MCP'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 MCP has been awarded a Medicaid provider agreement for a specific region and annually thereafter.

At a minimum, the information shall include the following:

i. The information's purpose;

ii. Claims submission information including the MCP's Medicaid provider number for each region (this information is only required to be provided to non-panel FQHCs/RHCs, QFPPs, CNMs, CNPs, and hospitals);

iii. The MCP's prior authorization and referral procedures;

iv. A picture of the MCP's member ID card (front and back);

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

vi. A listing of the MCP's laboratories and radiology providers.

b. **MCP-authorized Providers.** The MCP authorizing the delivery of services from a non-panel provider shall ensure they have a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of OAC rule 5160-26-05. This notice is provided when the MCP authorizes a non-panel provider to furnish services on a one-time or infrequent basis to the MCP member and shall include required ODM-model language and information. This notice shall also be included with the transition of services form sent to providers as outlined in Appendix C.

c. Upon request, the MCP shall provide information to ODM to document the non-contracting providers identified by the MCP and the information provided to each provider. If the MCP requires referrals to specialists, they 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 MCP shall comply with MHPAEA requirements outlined in 42 CFR Part 438 Subpart K, with regard to services provided to managed care members. The requirements apply to the provision of all covered benefits to all populations included under the terms of this Agreement. The MCP shall:

a. Demonstrate to ODM that all covered services are being delivered in compliance with the MHPAEA regulation.

i. Prior to implementing a change to any behavioral health policy, including pharmacy, inpatient, outpatient, and emergency benefits, the MCP must complete an MHPAEA analysis to determine compliance.

ii. At least 30 calendar days prior to implementing a change to BH policy, the MCP must attest in writing to ODM that the MHPAEA analysis was completed and that the policy change does not impact MHPAEA compliance.

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 MCP's covered services, the MCP 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 MCP.

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 MCP 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 MCP 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 MCP.

        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 MCP shall adequately and timely cover services provided by an out-of-network provider if the MCP's contracted provider panel is unable to provide the services covered under this Agreement. The MCP shall cover the out-of-network services for as long as the MCP network is unable to provide the services. The MCP 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 MCP shall ensure services are available 24 hours a day, 7 days a week, when medically necessary. The MCP 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 demonstrate adequate provider panel capacity and services, 42 CFR 438.206 and 438.207 stipulates that the MCP shall submit documentation to the Ohio Department of Medicaid (ODM), in a format specified by ODM, that demonstrates it offers an appropriate range of preventive, primary care, behavioral health, family planning, and specialty services adequate for the anticipated number of members in the service area, while maintaining a provider panel 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 MCP enters into a contract with ODM; at any time there is a significant change (as defined by ODM) in the MCP's operations that would affect adequate capacity and services (including changes in services,

benefits, geographic service or payments); on an annual basis; and at any time there is enrollment of a new population in the MCP.

2. **General Provisions.** The ODM provider panel requirements are specified in the charts included with this appendix and shall be met prior to the MCP receiving a provider agreement with ODM. The MCP shall remain in compliance with these requirements for the duration of the provider agreement.

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

    b. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit as specified in Appendix C.

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

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

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

3. **Provider Subcontracting.** Unless otherwise specified in this appendix or OAC rule 5160-26-05, the MCP is required to enter into fully-executed subcontracts with their 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 MCP'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 MCP shall either:

1. Validate that the provider is:

    a. Active on the Provider Master File; and

    b. Enrolled for the service and specialty, as applicable; or

2. Direct a new provider to the ODM public portal to submit application for screening and enrollment prior to contracting.

ii. In accordance with 42 CFR 438.602, an MCP may execute a temporary 120 calendar day network provider agreement pending the outcome of the ODM screening, enrollment and revalidation process. The MCP 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 MCP 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 MCP 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 MCP 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.

c. The MCP shall credential/re-credential providers in accordance with OAC rule 5160-26-05. The MCP shall ensure the provider has met all applicable credentialing criteria before the provider can be listed as a panel provider. Upon implementation of centralized credentialing, the process by which all Medicaid providers shall go through the credentialing process adhering to CMS standards directly at ODM, the MCP shall only utilize ODM-credentialed providers within their provider panel, and shall provide the following information about credentialed providers to ODM upon request:

i. Date of last credentialing approval of both facilities and practitioners;

ii. Name, NPI, and MCN of facilities and practitioners;

iii. Full file utilized to credential facilities and practitioners (include all PSV);

iv. Date and result of last site survey or name of certification/expiration date of certification for facilities; and

v. Demographic information for practitioners including: malpractice insurance information, self-disclosed malpractice claims, hospital privileges, board certification names and expiration dates, DEA numbers and expiration dates, work history information, and education and training.

d. At the direction of ODM, the MCP shall submit documentation verifying that all necessary provider contract documents have been appropriately completed.

e. The MCPN is a centralized database system that maintains information on the status of all MCP-submitted providers. The MCP shall notify ODM of the addition and deletion of their contracting providers as specified in OAC rule 5160-26-05, and shall notify ODM within one business day, in instances where the MCP has identified that they are not in compliance with the provider panel requirements specified in this appendix. For provider deletions, the MCP shall complete and submit an electronic record terminating the provider from the MCPN or other designated system.

4. **Provider Panel Requirements.** The provider network criteria that shall be met by the MCP is as follows:

a. **Primary Care Providers (PCPs).** PCP means an individual physician (M.D. or D.O.), certain physician group practice/clinic (Primary Care Clinics [PCCs]), physician assistants, or an advanced practice registered nurse (APRN) as defined in ORC section 4723.43 or advanced practice nurse group practice within an acceptable specialty, contracting with the MCP to provide services as specified in OAC rule 5160-26-03.1. Acceptable specialty types for PCPs include family/general practice, internal medicine, and pediatrics. Acceptable PCCs include FQHCs, RHCs, and the acceptable group practices/clinics specified by ODM. In order for the PCP to count toward minimum provider panel requirement, as part of the MCP's subcontract with a PCP, the MCP shall ensure the total Medicaid member capacity is not greater than 2,000 for that individual PCP.

The PCP capacity for a county is the total amount of members that all of the PCPs in the MCP agree to serve in that county. ODM will determine the PCP capacity based on information submitted by the MCP through the MCPN. The PCP capacity shall exceed by at least 5% the total number of members enrolled in the MCP during the preceding month in the same county.

ODM will determine the MCP's compliance with the PCP capacity requirement each quarter using the ODM enrollment report for the previous month. For example, in April, ODM will review the MCP's countable PCP capacity using one of the April MCPN reports. The countable capacity will be compared to the finalized enrollment report for March.

ODM recognizes that some members needing specialized care will use specialty providers as PCPs. In these cases, the MCP will submit the specialist to the MCPN database as a PCP. However, the specialist serving as a PCP will not count toward minimum provider panel PCP requirements, even though they are coded as a PCP. Also, in some situations (e.g., continuity of care) a PCP may only want to serve a very small number of members for the MCP. These PCPs will, however, need to execute a subcontract with the MCP which includes the appropriate Model Medicaid Addendum.

In addition to the PCP capacity requirement, the MCP shall also contract with the specified number of pediatric PCPs for each region. These pediatric PCPs will have their stated capacity counted toward the PCP capacity requirement.

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

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

c. **All Other Provider Network Requirements.** In addition to the PCP capacity requirements, the MCP is also required to maintain adequate access in the remainder of its provider network within the following categories: hospitals, dentists, vision care providers, OB/GYNs, allergists, cardiovascular, gastroenterology, nephrology, neurology, oncology, outpatient dialysis, physical medicine, pediatrician, pediatric dentistry, pediatric behavioral health, behavioral health, podiatry, psychiatry, urology, general surgeons, otolaryngologists, orthopedists. QHCs/RHCs, QFPPs, CNMs, CNPs, FQHCs/RHCs, and QFPPs are federally-required provider types.

All Medicaid-contracting MCPs shall provide all medically-necessary Medicaid-covered services to their members and therefore their complete provider network will include many other additional specialists and provider types. The MCP shall ensure all non-PCP 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).

i. **Hospitals**. The MCP shall contract with the number and type of hospitals specified by ODM for each county/region identified in Table 2. In developing these hospital requirements, ODM considered, on a county-by- county basis, the population size and utilization patterns of the Ohio Medicaid ABD, MAGI, and Adult Extension consumers and integrated the existing utilization patterns into the hospital network requirements to avoid disruption of care. For this reason, ODM may require that the MCP contract with out-of- state hospitals (i.e. Kentucky, West Virginia, etc.).For each Ohio hospital, ODM utilizes the hospital's most current Annual Hospital Registration and Planning Report, as filed with the Ohio Department of Health (ODH), in verifying types of services

that hospital provides. Although ODM has the authority, under certain situations, to obligate a non-contracting hospital to provide non-emergency hospital services to the MCP's members, the MCP shall still contract with the specified number and type of hospitals unless ODM approves a provider panel exception (see Provider Panel Exceptions in this appendix).

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

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

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

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

iv. **Vision Care Providers**. The MCP shall contract with at least the minimum number of ophthalmologists/ optometrists for each specified county/region, all of whom shall maintain a full-time practice at a site(s) located in the specified county/region to count toward minimum panel requirements. All ODM-approved vision providers shall regularly perform routine eye exams.

The MCP will be expected to contract with an adequate number of ophthalmologists as part of their overall provider panel, but only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care provider panel requirement. If optical dispensing is not sufficiently available in a region through the MCP's contracting ophthalmologists/optometrists, the MCP shall separately contract with an adequate number of optical dispensers located in the region.

v. **Dental Care Providers**. The MCP shall contract with at least the minimum number of dentists identified in Table 6. Dental providers shall serve adult members and members

under the age of 18 to count towards capacity.

vi. **Other Specialty Types**. Allergists, pediatricians, general surgeons, otolaryngologists, orthopedists for the MAGI population, and general surgeons, otolaryngologists, orthopedists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, podiatrists, physiatrists, psychiatrists, and urologists for the ABD and Adult Extension populations. The MCP shall contract with at least the minimum number of ODM designated specialty provider types. In order to be counted toward meeting the provider panel requirements, these specialty providers shall maintain a full-time practice at a site(s) located within the specified county/region.

vii. **FQHCs/RHCs**. The MCP is required to ensure member access to any FQHCs/RHCs, regardless of contracting status. Contracting FQHC/RHC providers shall be submitted for ODM review via the MCPN process, or other designated process. Even if no FQHC/RHC is available within the region, the MCP shall have mechanisms in place to ensure coverage for FQHC/RHC services in the event that a member accesses these services outside of the region. The MCP shall also educate their staff and providers on the need to ensure member access to FQHC/RHC services.

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

1. The MCP shall provide expedited payment for a service-specific basis in an amount no less than the payment made to other providers for the same or similar service.

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

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

viii. **Qualified Family Planning Providers (QFPPs).** All MCP members shall be permitted to self- refer for services and supplies allowed under Title X of the Public Health Services Act (Title X services) provided by a QFPP. A QFPP is defined as any public or not-for-profit health care provider that complies with Title X guidelines/standards and receives either Title X funding or family planning funding from the ODH. The MCP shall reimburse all medically-necessary Medicaid-covered Title X services provided to eligible members by a QFPP provider (including on-site pharmacy and diagnostic services) on a patient self-referral basis, regardless of the provider's status as a panel or non-panel provider. A description of Title X services can be found on the ODH website. The MCP will be required to work with QFPPs in the region to develop mutually-agreeable HIPAA compliant policies and procedures to preserve patient/provider confidentiality and convey pertinent information to the member's PCP and/or MCP.

ix. **Behavioral Healthcare Providers**. The MCP shall ensure member access to all Medicaid-covered behavioral health (BH) services for members as specified in Appendix G. The MCP must contract with Ohio Department of Mental Health and Addiction Services (OhioMHAS)-certified Community Mental Health Centers (CMHCs) and Substance Use Disorder (SUD) treatment providers for the provision of behavioral health services in order to comply with the tables within this appendix.

1. **Substance Use Disorder (SUD) Treatment Providers.** The MCP shall ensure adequate provider panel capacity exists to provide its members with reasonable and timely access to all state plan SUD treatment services.

2. **Medication Assisted Treatment (MAT) Prescribers**. The MCP shall contract with at least the minimum number of MAT prescribers identified in Table 5, 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 MCP's required number of contracted MAT prescribers. Noncompliance with MAT prescriber contracting requirements will be enforced beginning July 1, 2019. The MCP shall report any additional providers prescribing MAT not previously identified by ODM as specified by ODM.

3. **Community Mental Health Centers (CMHCs).** The MCP shall ensure adequate provider panel capacity to provide its members with reasonable and timely access to all state plan mental health services.

4. **Other Behavioral Health Providers.** The MCP shall contract with at least the minimum number behavioral health providers identified in Table 4. 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.

x. **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 MCP 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 MCP that is it providing services and billing as a qualified laboratory under this requirement.

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

xii. **Specialized Pharmacies.** The MCP shall accept into their pharmacy network any specialty pharmacy that meets the MCP's specific standards and can provide services at the same or lower cost compared to other in-network specialty pharmacies.

5. **Provider Panel Exceptions.** Failure to contract with, and properly report to the MCPN, all MCP-contracted providers will result in sanctions as outlined in Appendix N. ODM will grant an exception to the issuance of a sanction only when an action taken by ODM has adversely impacted a plan's ability to meet the provider panel network standards.

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

    a. MCP provider directories shall utilize a format specified by ODM. Directories 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:

        i. Provider's name as well as any group affiliation;

        ii. Provider's street address(es);

        iii. Provider's telephone number(s);

        iv. Provider's website URL, as appropriate;

        v. Provider's specialty, when applicable;

        vi. Indication of the provider's office/facility accessibility and accommodations (e.g. offices, exam room(s), and equipment), when applicable;

        vii. Indication of whether the provider offers telehealth, and if so, when telehealth is available;

        viii. Indication of whether the provider is accepting new members;

        ix. 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;

        x. Provider's cultural competence training status, when available;

xi. 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; and

xii. The MCP 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**. Prior to executing a provider agreement with ODM, the MCP shall develop a printed provider directory that shall be prior-approved by ODM. Once approved, in accordance with 42 CFR 438.10, this directory content may be updated with provider additions or deletions by the MCP without ODM prior-approval. Any revisions to the printed provider directory format must be approved by ODM before distribution.

c. **Internet Provider Directory**. The MCP is required to have an internet-based provider directory available in a format prior approved by ODM. Any revisions to the internet provider directory format must be approved by ODM before implementation. This internet directory shall allow members to electronically search for MCP panel providers based on name, provider type, provider specialty, and geographic proximity. If the MCP has one internet-based directory for multiple populations, each provider shall include a description of which population they serve. If the MCP receives updated provider information, this directory shall be updated in accordance with the timeframes listed in 42 CFR 438.10.

7. **Managed Care Provider Network Performance Measures.** ODM contracts with an External Quality Review Organization (EQRO), to conduct telephone surveys of providers' offices to validate information submitted in the MCPN files. These results will be used to evaluate MCP performance on a biannual basis. Sanctions for these measures are included in Appendix N of this agreement. The following elements have a baseline that shall be met with the statewide results:

a. **Rate of Primary Care Provider Locations.** Measure 1 (M1) Rate of primary care provider (PCP) locations that were able to be reached. The data updated by the MCPs in ODM's system shall be accurate 70% of the time for the statistically valid statewide sample.

Measure 1 (M1) identifies the proportion of the PCP locations not reached during a biannual audit. The PCP was considered "not reached" if the provider is no longer practicing at the sampled location or the provider did not return phone calls after the EQRO made two attempts at different times during the survey. The measure is an inverse measure such that the higher the

percentage of PCP locations not reached, the lower the level of performance.

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

b. **Number of PCP Locations**. Measure 2 (M2) Participating PCP locations still contracted with the MCP.

For Measure 2, the baseline of 92% was established using the previous 2 cycles of data collection. The MCP shall ensure the contracting status of the statistically valid statewide sample is met 92% of the time.

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

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

c. ODM collected the first two years of performance measures and additional research to create a baseline for the two measures.

   i. **Measure 1 – PCP Locations Not Reached.** The data updated by the MCPs in ODM's system shall be accurate 70% of the time for the statistically valid statewide sample.

   ii. **Measure 2 – PCP Locations Not Contracted With MCP.** For Measure 2, the baseline of 92% was established using the previous 2 years of collected data of members that were reached MCPs shall ensure the contracting status of the statistically valid statewide sample is met 92% of the time.

Table 1. Network Capacity Minimum Standards. ODM will utilize a time and distance geo mapping software that uses the Euclidean metric to measure the maximum time and distance, and the MCP must ensure that at least 90% of the MCP's membership residing in a given county have access to at least one provider/facility of each specialty type within the time and distance standards in the chart below. In order to satisfy the requirement for time and distance measure, ODM evaluates the MCP's membership with the MCP provider coordinates. Since ODM is using the MCPs' data, the MCP assure the data is clean and accurate.

Specialty	Geographic Type							
	Large Metro		Metro		Micro		Rural	
	Maximum Time (minutes)	**Maximum Distance** (miles)	**Maximum Time** (minutes)	**Maximum Distance** (miles)	**Maximum Time** (minutes)	**Maximum Distance** (miles)	**Maximum Time** (minutes)	**Maximum Distance** (miles)
Adult Primary Care	10	5	15	10	30	20	40	30
Adult Dental	20	10	30	20	50	35	75	60
Allergy	30	15	53	35	80	60	90	75
Behavioral Health	20	10	30	20	50	35	75	60
Cardiology	20	10	38	25	60	45	75	60
Outpatient Dialysis	20	10	45	30	65	50	55	50
ENT/Otolaryngology	30	15	45	30	80	60	90	75
Gastroenterology	20	10	45	30	60	45	75	60
General Surgery	20	10	30	20	50	35	75	60
Gynecology, OB/GYN	30	15	45	30	80	60	90	75
Hospital	20	10	45	30	80	60	85	70
Nephrology	30	15	53	35	80	60	90	75
Neurology	20	10	45	30	60	45	75	60
Oncology	20	10	45	30	60	45	75	60
Orthopedics	20	10	38	25	50	35	75	60
Pediatrics	20	10	30	20	50	35	75	60
Pediatric Dentistry	20	10	30	20	50	35	75	60
Pediatric Behavioral Health	20	10	30	20	50	35	75	60
Pharmacy	10	5	15	10	30	20	40	30
Podiatry	20	10	45	30	60	45	75	60
Psychiatry	20	10	45	30	60	45	75	60
Radiology	20	10	45	30	80	60	75	60
Surgical Services - Outpatient	20	10	45	30	80	60	75	60
Urology	20	10	45	30	60	45	75	60

Table 2. Hospital Provider Panel.

County	General Hospital	Hospital System	Inpatient Psych Hospital
ADAMS	-	-	-
ALLEN	1	-	1
ASHLAND	1	-	-
ASHTABULA	1	-	-
ATHENS	1	-	-
AUGLAIZE	-	-	-
BELMONT	1	-	-
BROWN	-	-	-
BUTLER	-	-	1
CARROLL	-	-	-
CHAMPAIGN	-	-	-
CLARK	1	-	-
CLERMONT	-	-	1
CLINTON	1	-	-
COLUMBIANA	1	-	-
COSHOCTON	1	-	-
CRAWFORD	1	-	-
CUYAHOGA	1	1	6
DARKE	1	-	1
DEFIANCE	1	-	1
DELAWARE	-	-	-
ERIE	1	-	-
FAIRFIELD	1	-	-
FAYETTE	1	-	-
FRANKLIN	1	2	3
FULTON	1	-	1
GALLIA	1	-	1
GEAUGA	1	-	1
GREENE	1	-	-
GUERNSEY	1	-	-
HAMILTON	1	2	3
HANCOCK	1	-	1
HARDIN	-	-	-
HARRISON	-	-	-
HENRY	-	-	-
HIGHLAND	1	-	-
HOCKING	-	-	1
HOLMES	1	-	-
HURON	1	-	-
JACKSON	-	-	-
JEFFERSON	1	-	-
KNOX	1	-	-
LAKE	1	-	1
LAWRENCE	-	-	-
LICKING	1	-	1
LOGAN	1	-	-
LORAIN	1	-	-
LUCAS	-	1	2
MADISON	1	-	-
MAHONING	1	-	1
MARION	1	-	1
MEDINA	1	-	-
MEIGS	-	-	-
MERCER	1	-	-
MIAMI	1	-	1
MONROE	-	-	-
MONTGOMERY	1	1	1
MORGAN	-	-	-
MORROW	-	-	-
MUSKINGUM	1	-	1
NOBLE	-	-	-
OTTAWA	-	-	-
PAULDING	-	-	-
PERRY	-	-	-
PICKAWAY	1	-	-
PIKE	-	-	-
PORTAGE	1	-	-
PREBLE	-	-	-
PUTNAM	-	-	-
RICHLAND	1	-	-
ROSS	1	-	1
SANDUSKY	1	-	-
SCIOTO	1	-	-
SENECA	-	-	-
SHELBY	1	-	1
STARK	1	-	1
SUMMIT	1	1	1
TRUMBULL	1	-	1
TUSCARAWAS	1	-	-
UNION	1	-	-
VANWERT	1	-	-
VINTON	-	-	-
WARREN	-	-	1
WASHINGTON	1	-	-
WAYNE	1	-	-
WILLIAMS	1	-	-
WOOD	-	-	-
WYANDOT	1	-	-

Table 3. Nursing Facility Provider Panel.

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

Table 4. Other Behavioral Health Provider Panel (not provider types 84 or 95).

County	BH	County	BH	County	BH	County	BH
Adams	0	Fayette	0	Lorain	16	Richland	6
Allen	8	Franklin	24	Lucas	25	Ross	5
Ashland	1	Fulton	6	Madison	2	Sandusky	9
Ashtabula	8	Gallia	1	Mahoning	13	Scioto	1
Athens	5	Geauga	3	Marion	5	Seneca	0
Auglaize	0	Greene	14	Medina	13	Shelby	0
Belmont	2	Guernsey	1	Meigs	0	Stark	16
Brown	0	Hamilton	25	Mercer	3	Summit	29
Butler	17	Hancock	2	Miami	7	Trumbull	13
Carroll	0	Hardin	3	Monroe	0	Tuscarawas	4
Champaign	0	Harrison	0	Montgomery	20	Union	0
Clark	5	Henry	1	Morgan	0	Van Wert	1
Clermont	4	Highland	0	Morrow	0	Vinton	0
Clinton	2	Hocking	2	Muskingum	6	Warren	7
Columbiana	7	Holmes	0	Noble	0	Washington	0
Coshocton	2	Huron	3	Ottawa	1	Wayne	4
Crawford	0	Jackson	2	Paulding	0	Williams	3
Cuyahoga	55	Jefferson	0	Perry	0	Wood	12
Darke	1	Knox	5	Pickaway	2	Wyandot	0
Defiance	0	Lake	12	Pike	0		
Delaware	4	Lawrence	2	Portage	5		
Erie	5	Licking	4	Preble	0		
Fairfield	3	Logan	1	Putnam	0		

Table 5. Medication Assisted Treatment Provider Panel. Noncompliance with MAT prescriber contracting requirements will be enforced beginning July 1, 2019.

County	MAT	County	MAT	County	MAT	County	MAT
Adams	0	Fayette	1	Lorain	2	Richland	6
Allen	6	Franklin	43	Lucas	14	Ross	3
Ashland	0	Fulton	0	Madison	1	Sandusky	1
Ashtabula	2	Gallia	2	Mahoning	12	Scioto	8
Athens	3	Geauga	1	Marion	4	Seneca	0
Auglaize	0	Greene	5	Medina	1	Shelby	0
Belmont	1	Guernsey	1	Meigs	2	Stark	6
Brown	0	Hamilton	30	Mercer	0	Summit	14
Butler	8	Hancock	1	Miami	2	Trumbull	4
Carroll	0	Hardin	1	Monroe	0	Tuscarawas	1
Champaign	0	Harrison	0	Montgomery	18	Union	0
Clark	2	Henry	0	Morgan	1	VanWert	0
Clermont	4	Highland	1	Morrow	0	Vinton	1
Clinton	0	Hocking	3	Muskingum	3	Warren	4
Columbiana	3	Holmes	0	Noble	0	Washington	0
Coshocton	0	Huron	1	Ottawa	0	Wayne	1
Crawford	1	Jackson	0	Paulding	0	Williams	1
Cuyahoga	34	Jefferson	0	Perry	2	Wood	2
Darke	0	Knox	1	Pickaway	2	Wyandot	0
Defiance	1	Lake	4	Pike	1		
Delaware	1	Lawrence	1	Portage	2		
Erie	2	Licking	4	Preble	0		
Fairfield	3	Logan	2	Putnam	0		

Table 6. Dental and Vision Provider Panel. The Dental standards require that the provider not only practice at least 25 hours per week, but they also be willing to serve adult members and members under the age of 18.

Region	County	Dental	Vision
W	ADAMS	1	-
W	ALLEN	5	3
NE	ASHLAND	3	-
NE	ASHTABULA	3	3
CEN/SE	ATHENS	3	3
W	AUGLAIZE	1	1
CEN/SE	BELMONT	4	4
W	BROWN	1	-
W	BUTLER	13	4
NE	CARROLL	-	-
W	CHAMPAIGN	1	-
W	CLARK	6	3
W	CLERMONT	5	1
W	CLINTON	1	2
NE	COLUMBIANA	3	-
CEN/SE	COSHOCTON	3	1
CEN/SE	CRAWFORD	1	2
NE	CUYAHOGA	102	32
W	DARKE	1	1
W	DEFIANCE	-	2
CEN/SE	DELAWARE	3	3
NE	ERIE	2	2
CEN/SE	FAIRFIELD	4	3
CEN/SE	FAYETTE	1	-
CEN/SE	FRANKLIN	95	20
W	FULTON	-	-
CEN/SE	GALLIA	1	2
NE	GEAUGA	1	1
W	GREENE	3	3
CEN/SE	GUERNSEY	3	2

Region	County	Dental	Vision
W	HAMILTON	50	14
W	HANCOCK	2	1
W	HARDIN	1	-
CEN/SE	HARRISON	-	-
W	HENRY	1	-
W	HIGHLAND	3	2
CEE/SE	HOCKING	1	-
NE	HOLMES	-	-
NE	HURON	2	2
CEN/SE	JACKSON	1	2
CEN/SE	JEFFERSON	3	3
CEN/SE	KNOX	3	2
NE	LAKE	6	6
CEN/SE	LAWRENCE	3	3
CEN/SE	LICKING	4	2
CEN/SE	LOGAN	1	2
NE	LORAIN	11	11
W	LUCAS	29	9
CEN/SE	MADISON	1	-
NE	MAHONING	14	5
CEN/SE	MARION	3	2
NE	MEDINA	4	4
CEN/SE	MEIGS	-	-
W	MERCER	1	-
W	MIAMI	3	-
CEN/SE	MONROE	-	-
W	MONTGOMERY	25	-
CEN/SE	MORGAN	-	-
CEN/SE	MORROW	1	-
CEN/SE	MUSKINGUM	4	4

Region	County	Dental	Vision
CEN/SE	NOBLE	1	-
W	OTTAWA	1	-
W	PAULDING	-	-
CEN/SE	PERRY	1	-
CEN/SE	PICKAWAY	1	1
CEN/SE	PIKE	1	-
NE	PORTAGE	3	-
W	PREBLE	-	-
W	PUTNAM	1	-
NE	RICHLAND	7	2
CEN/SE	ROSS	4	2
W	SANDUSKY	3	-
CEN/SE	SCIOTO	2	2
W	SENECA	2	-
W	SHELBY	1	-
NE	STARK	17	7
NE	SUMMIT	23	13
NE	TRUMBULL	11	4
NE	TUSCARAWAS	4	-
CEN/SE	UNION	1	1
W	VANWERT	2	-
CEN/SE	VINTON	-	-
W	WARREN	1	-
CEN/SE	WASHINGTON	3	2
NE	WAYNE	3	-
W	WILLIAMS	1	-
W	WOOD	2	-
W	WYANDOT	1	-

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX I

PROGRAM INTEGRITY

The MCP shall comply with all applicable state and federal program integrity requirements, including, but not limited to, those specified in Ohio Administrative Code (OAC) rule 5160-26-06, 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 rule 5160-26-06, the MCP shall have a program that includes administrative and management arrangements or procedures to detect and prevent fraud, waste, and abuse. The MCP's compliance program shall address the following:

    a. **Compliance Program**. In accordance with 42 CFR 438.608, the MCP 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 MCP 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 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 MCP's compliance program.

        v. A system for training and education for the Compliance Officer, the MCP's senior management, and the MCP's employees regarding the MCP's compliance program and program integrity related requirements.

        vi. Effective lines of communication between the Compliance officer and the MCP'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. Establishment and/or modification of internal MCP controls to ensure the proper submission and payment of claims.

b. **Fraud, Waste, and Abuse Program.** In accordance with 42 CFR 438.608, the MCP shall create, implement, and maintain a fraud, waste, and abuse program that includes all the following:

i. Education of providers and delegated entities about fraud, waste, and abuse.

ii. 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.

iii. An Ohio-specific fraud, waste, and abuse plan. The MCP shall submit the Ohio-specific fraud, waste, and abuse plan within 90 days of this contract's execution and annually thereafter. ODM shall provide notice of approval, denial, or modification of the plan to the MCP within 30 days of receipt. The MCP shall make any requested updates or modifications available for review and approval as requested by ODM within 30 calendar days of receipt.

1. 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 MCP will determine effectiveness of the plan. The fraud, waste, and abuse plan shall include, but is not limited to, the following:

2. A risk-based assessment which shall include the MCP's evaluation of its fraud, abuse, and program integrity processes.

3. A risk-based assessment which shall include the MCP's evaluation of risk for fraud and abuse in the provision of services by providers to Medicaid beneficiaries.

4. An outline of activities proposed by the MCP for the next reporting year which is established from the risk-based assessment results.

5. An outline of activities proposed by the MCP for the next reporting year regarding provider education of federal and state laws and regulations related to Medicaid program integrity and identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments.

6. 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.

7. 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.

c. **Employee Education about False Claims Recovery**. The MCP shall comply with Section 6032 of the Deficit Reduction Act of 2005 regarding employee education and false claims recovery, specifically the MCP shall:

i. Establish and make readily available to all employees, including the MCP'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 MCP'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 MCP shall communicate the following whistleblower fraud and/or abuse reporting contacts to all employees, providers, and subcontractors:

a. Ohio Department of Medicaid (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 MCP contractors and agents that provide detailed information about the Federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements, as well as civil or criminal penalties; the laws governing the rights of employees to be protected as whistleblowers; and the MCP's policies and procedures for detecting and preventing fraud, waste, and abuse. The MCP 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.

d. **Monitoring for Fraud, Waste, and Abuse**. The MCP shall specifically address the MCP's strategies for prevention, detection, investigation, and reporting in at least the following areas:

i. **Credible allegations of fraud**. The MCP 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 MCP shall annually review their prior authorization (PA) procedures to determine if they unreasonably limit a member's access to Medicaid-covered services;

2. The MCP shall annually review their appeals process for providers following the MCP'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 MCP 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 MCP shall immediately investigate and, if indicated, correct the problem(s).

iii. **Claims submission and billing**. On an ongoing basis, the MCP 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 MCP 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. 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 MCP shall ensure that the SIU lead participates in all MCPIG meetings, the Biweekly Home Health Care Fraud Referral meeting, and holds quarterly SIU lead meetings to discuss fraud referrals and other program integrity issues.

3. **Reporting MCP monitoring of fraud, waste, and abuse activities.** Pursuant to OAC rule 5160-26-06, the MCP shall report annually to ODM a summary of the MCP'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 MCP's report shall also identify any proposed changes to the MCP's compliance plan for the coming year.

    a. **Reporting suspected fraud, waste, and abuse**. The MCP 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. If the MCP 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 MCP 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 MCP shall immediately suspend all payments to the provider and shall 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, or federal agencies, the MCP shall produce copies of all MCP fraud, waste, and abuse investigatory files and data (including, but not limited to records of recipient and provider interviews) in 30 calendar days unless otherwise agreed upon by ODM.

ii. **Credible allegation of member fraud**. All suspected enrollee fraud and abuse shall be immediately reported to Bureau of Program Integrity (BPI) at Program_Integrity_County_Referral@medicaid.ohio.gov and copy the appropriate county department of job and family services (CDJFS).

b. **Referrals and Attestations**. The MCP 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 MCPs.

c. The ODM Clearinghouse shall review all fraud, waste, and abuse referrals from the MCP 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 MCP.

d. The MCP 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 MCP waiving its right to participate in any Attorney General Office (AGO) MFCU recoveries.

e. **Monitoring for prohibited affiliations**. The MCP's policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the MCP will not knowingly have a relationship 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 MCP 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 this Agreement held by the non-institutional Medicaid provider, at the direction of ODM, the MCP 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 MCP shall disclose any change in ownership and control information and this information shall be furnished to ODM 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 MCP 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 MCP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

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

i. The MCP 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 this Agreement if it determines that the provider did not fully and accurately make any disclosure referenced in this section.

j. The MCP shall notify ODM when the MCP denies credentialing to providers for program integrity reasons.

k. The MCP 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 panel provider agreement is terminated for program integrity reasons. The MCP shall provide the reason for the denial or termination.

l. The MCP 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 potential 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 against a provider, during the

previous contracting period and for each ongoing quarter.

m. **Coordination with Law Enforcement.** The MCP 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 MCP submission of a fraud, waste, or abuse referral to ODM, the MCP 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**. Prior to initiating an audit, investigation, review, recoupment or withhold, or involuntarily terminating a provider, the MCP must request deconfliction and receive permission from ODM to proceed.

1. The MCP 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. The AGO MFCU has an open case, and the MCP 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 deconfliction request occurred prior to the date that the AGO MFCU opened their case on the same provider, and

c. The MCP submits a referral regarding the same provider after completion of its previously approved audit, investigation or review.

2. The MCP must stand down upon submission of a deconfliction request for fraud, waste or abuse. ODM will either grant the deconfliction request or notify the MCO to stand down. The stand down time-period or the time period to conduct approved program activities is valid for six months. . After the six month period expires, the MCP shall submit another deconfliction request to conduct activities as identified above to ensure that the requested action will not interfere in a law enforcement investigation or other law enforcement activities. The deconfliction request must be granted by ODM for the MCP to proceed with

the requested action.

a. The Program Integrity Director may extend the stand down for 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.

iii. **Recoupments and Recoveries.**

1. The MCP 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 MCP 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.

2. Absent any restrictions on recovery, the MCP may otherwise recover from a provider any amount collected from the MCP 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 MCP which resulted from an audit, review or investigation of the provider. The MCP shall retain recovery rights to any amount paid to ODM when a provider self-reports an overpayment arising from a payment made by the MCP to the provider or other reason.

3. The MCP 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 such 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. Non-federally qualified MCPs 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].

o. **Treatment of Recoveries made by the MCP from Overpayments to Providers.**

i. Pursuant to 42 CFR 438.608, the MCP shall:

1. Immediately notify ODM BPI if the MCP acts to recoup an overpayment related to fraud, waste, and abuse without requesting deconfliction. ODM BPI will issue written instructions, including any applicable timeframes, in response to the notification of overpayment recoupment and the MCP shall comply with those instructions; and

2. Require any network provider to report to the MCP when it has received an overpayment, to return the overpayment to the MCP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCP in writing of the reason for the overpayment.

ii. If the MCP seeks to recoup an overpayment made to a provider, the MCP shall provide the provider all of the details of the recoupment as specified in ORC section 5167.22.

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 MCP is required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to ODM which may affect MCP payment.

a. **MCP Submissions**. The MCP shall submit the appropriate ODM-developed certification concurrently with the submission of the following data or documents:

i. Encounter Data, Care Management Data, HEDIS IDSS Data/FAR, and CAHPS Data as specified in Appendix L; and

ii. Prompt Pay Reports and Cost Reports as specified in Appendix J.

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

i. The MCP's Chief Executive Officer;

ii. The MCP's Chief Financial Officer; or

iii. An individual who has delegated authority to sign for, and who reports directly to, the MCP's Chief Executive Officer or Chief Financial Officer. When the authorization is delegated to another MCP employee, the CEO or CFO remains responsible.

c. The MCP 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 MCP shall have a method for verifying with enrollees whether services billed by providers were received; therefore, the MCP is required to conduct a mailing of EOBs to a 95% confidence level (plus or minus 5% margin of error) random sample of the MCP's enrollees once a year. As an option, the MCP may meet this requirement

by using a strategy targeting services or areas of concern as long as the number of mailed EOBs is not less than the number generated by the random sample described above. If the MCP opts to use a targeted mailing, they 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 that the enrollee report any discrepancies to the MCP. The MCP shall inform the Program Integrity Liaison for Managed Care and their 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). The MCP shall perform ad hoc EOB targeted mailings at the request of the Program Integrity Director.

6. **Breaches of Protected Health Information**. The MCP 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. **Cooperation with State and Federal Authorities.** The MCP 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 MCP shall provide the data within 30 calendar days. The MCP shall cooperate fully with State and Federal Authorities and:

    a. The MCP 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 MCP subcontractors, employees, and consultants in any manner related to the investigation, and witnesses for trial and other legal or administrative proceedings. The MCP shall provide the information requested, even if the information is housed with the MCP's subcontractor or vendor. The MCP shall fulfill the request(s) for production of information, records, and witnesses, as well as, other items requested by law enforcement's interview within 30 days, unless the MCP received leave from ODM to extend the time.

    b. The MCP, subcontractors, and the MCPs' 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. **Submission of Financial Statements and Reports.** The MCP shall submit the following financial statements and reports to ODM:

    a. Quarterly National Association of Insurance Commissioners (NAIC) Health Statements (hereinafter referred to as "financial statements") which shall include all required Health Statement filings, schedules, and exhibits as stated in the NAIC Annual Health Statement instructions including, but not limited to, the following sections: Assets, Liabilities, Capital and Surplus Account, Cash Flow, Analysis of Operations by Lines of Business, Five-Year Historical Data, and the Exhibit of Premiums, Enrollment and Utilization, and the Modified Supplemental Health Care Exhibit.

        i. The financial statements shall be submitted to ODM even if the Ohio Department of Insurance (ODI) does not require the MCP to submit these statements to ODI.

        ii. An electronic copy of the reports in the NAIC-approved format shall be provided to ODM.

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

    c. Annual NAIC/Cost Report Reconciliation as specified by ODM.

    d. **Quarterly and Annual Medicaid MCP ODM Cost Reports for All Covered Populations.**

        i. The annual and quarterly cost reports shall adhere to the Agreement and be submitted in accordance with the cost report instructions and within established timeframes.

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

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

    e. Annual physician incentive plan disclosure statements, and disclosure of and changes to the MCP's physician incentive plans, in accordance with 42 CFR 438.3.

    f. Fully-executed reinsurance agreements shall be submitted to ODM prior to the effective date of this Agreement.

    g. Prompt Pay Reports). An electronic copy of the reports in the ODM-specified format shall be provided to ODM.

h. Notification of requests for information and copies of information released pursuant to a tort action (i.e., third party recovery), as outlined in OAC rule 5160-26-09.1.

i. Financial, utilization, and statistical reports, when ODM requests such reports, based on a concern regarding the MCP's quality of care, delivery of services, fiscal operations or solvency, in accordance with OAC rule 5160-26-06(D).

j. The MCP shall submit ODM-specified reports for the calculation of items 2.b-d below in electronic formats.

2. **Financial Performance Measures and Standards.** This appendix establishes specific expectations concerning the financial performance of the MCP. In the interest of administrative simplicity and non-duplication of areas of ODI authority, ODM's emphasis is on the assurance of access to and quality of care. ODM will focus only on a limited number of indicators and related standards to monitor MCP financial performance. The five indicators and standards for this Agreement period are identified below. The source for each indicator will be the NAIC Quarterly and Annual Financial Statements and Modified Supplemental Health Care Exhibit or other sources indicated by ODM. The measurement period that will be used to determine compliance will be the contract year.

   a. **Indicator**: Current Ratio. Refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Current Ratio.

      Standard: The Current Ratio shall not fall below 1.00 as determined from the annual Financial Statement submitted to ODI and ODM.

   b. **Indicator**: Medical Loss Ratio**.** Refer to 42 CFR 438.8 for the definition and calculations for the Medical Loss Ratio indicator. The MCP shall comply with documentation and submission requirements as specified by ODM for the annual MLR calculation.

      Standard: Minimum Medical Loss Ratio shall not fall below 86%.

   c. **Indicator**: Administrative Expense Ratio. Refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Administration Expense Ratio indicator.

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

   d. **Indicator**: Overall Expense Ratio. Refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Overall Expense Ratio indicator.

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

   e. **Indicator**: Defensive Interval. Refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Defensive Interval indicator.

Standard: The Defensive Interval shall not fall below 30 calendar days as determined from the annual Financial Statement submitted to ODI and ODM.

Long-term investments that can be liquidated without significant penalty within 24 hours, which the MCP includes in cash and short-term investments in the financial performance measures, shall be disclosed in footnotes on the NAIC Reports. Descriptions and amounts shall also be disclosed. Please note that "significant penalty" for this purpose is any penalty greater than 20%. The MCP shall enter the amortized cost of the investment, the market value of the investment, and the amount of the penalty.

3. **Reinsurance Requirements.** The MCP shall carry reinsurance coverage from a licensed commercial carrier to protect against inpatient-related medical expenses incurred by Medicaid members. To the extent that the risk for such expenses is transferred to a subcontractor, the MCP shall provide proof of reinsurance coverage for that subcontractor in accordance with this Agreement. The reinsurance coverage shall remain in force during the term of this Agreement and shall contain adequate provisions for contract extensions. In the event of termination of the reinsurance agreement due to insolvency of the MCP or the reinsurance carrier, the MCP will be fully responsible for all pending or unpaid claims, and any reinsurance agreements that cover expenses to be paid for continued benefits in the event on insolvency shall include Medicaid members as a covered class.

   The MCP shall provide written notification to ODM when directed by ODM, specifying the dates of admission, diagnoses, and estimates of the total claims incurred for all Medicaid members for which reinsurance claims have been submitted.

   The annual deductible or retention amount for such insurance shall be specified in the reinsurance agreement and shall not exceed $100,000.00, unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. Except for transplant services, and as provided below, this reinsurance shall cover, at a minimum, 80% of inpatient costs incurred by one member in one year, in excess of $100,000.00 unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement.

   For transplant services, the reinsurance shall cover, at a minimum, 50% of inpatient transplant related costs incurred by one member in one year, in excess of $100,000.00 unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement.

   Any proposed changes or modifications to the reinsurance agreement shall be submitted to ODM in writing for review and approval 30 calendar days prior to the intended effective date and shall include the complete and exact text of the proposed change. The MCP shall provide copies of new or modified reinsurance agreements to ODM within 30 calendar days of execution.

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

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

b. The MCP's history in complying with financial indicators as specified in this appendix;

c. The number of members covered by the MCP;

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

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

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

4. **Prompt Pay Requirements.** In accordance with 42 CFR 447.46, the MCP shall pay 90% of all submitted clean claims within 30 calendar days of the date of receipt and 99% of such claims within 90 calendar days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule mutually agreed upon and described in their contract. The claim types listed below will be separately measured against the 30 and 90 calendar day prompt pay standards:

   a. **Clean nursing facility claims**.

      i. The MCP shall pay 90% of all clean nursing facility claims within 30 calendar days of the date of receipt.

      ii. 99% of such claims within 90 calendar days of the date of receipt.

   b. **Clean pharmacy claims**.

      i. The MCP shall pay 90% of all clean pharmacy claims within 30 calendar days of the date of receipt.

      ii. 99% of such claims within 90 calendar days of the date of receipt.

   c. **Clean behavioral health claims.**

      i. The MCP shall pay 90% of all clean behavioral health claims within 15 calendar days of the date of receipt.

      ii. 99% of such claims within 60 calendar days of the date of receipt.

   d. **All other clean claim types** (excluding clean nursing facility, pharmacy, and behavioral health claims).

i. The MCP shall pay 90% of all other clean claim types (excluding clean nursing facility, pharmacy, and behavioral health claims) within 30 calendar days of the date of receipt.

ii. 99% of such claims within 90 calendar days of the date of receipt.

The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the MCP and delegated claims processing entities.

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

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

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

5. **Physician Incentive Plan Disclosure Requirements.** The MCP shall comply with the physician incentive plan requirements stipulated in 42 CFR 438.3(i)**.** If the MCP operates a physician incentive plan, no specific payment shall be made directly or indirectly under this physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

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

   In accordance with 42 CFR 417.479 and 42 CFR 422.210, the MCP shall maintain copies of the following required documentation and submit to ODM upon request:

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

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

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

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

e. Upon request by a member or a potential member, and no later than 14 calendar days after the request, the MCP shall provide the following information to the member:

    i. Whether the MCP uses a physician incentive plan that affects the use of referral services;

    ii. The type of incentive arrangement;

    iii. Whether stop-loss protection is provided; and

    iv. A summary of the survey results if the MCP was required to conduct a survey.

    The information provided by the MCP shall adequately address the member's request.

6. **Notification of Regulatory Action.** If the MCP is notified by the ODI of proposed or implemented regulatory action, they shall report such notification and the nature of the action to ODM no later than one business day after receipt from ODI. ODM may request, and the MCP shall provide, any additional information as necessary to ensure continued satisfaction of program requirements. The MCP may request that information related to such actions be considered proprietary in accordance with established ODM procedures. Failure to comply with this provision will result in an immediate enrollment freeze.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX K

QUALITY CARE

This appendix establishes program requirements and expectations related to MCP responsibilities for developing and implementing a population health management program; ensuring health, safety, and welfare for members; partnering with Comprehensive Primary Care (CPC) practices, Qualified Behavioral Health Entities, and Maternal & Infant Support Program Coordinating Entities to improve population health; coordinating with care management entities; coordinating activities for justice-involved individuals; developing and implementing a Quality Assessment and Performance Improvement (QAPI) program; and participating in external quality review activities. These program requirements support the priorities and goals set forth in Ohio Medicaid's Quality Strategy.

1. **Population Health Management.** The Ohio Department of Medicaid (ODM) seeks to improve the health of the Ohio Medicaid population by identifying and monitoring individual patients within specified groups. A well-designed population health management program is driven by clinical, financial, and operational data from internal departments and larger delivery systems providing actionable data that can be used to improve quality of care, patient experience, health equity, and cost of care.

   The MCP shall develop a model of care that broadly defines the way services will be delivered to meet population needs. The MCP shall address the following components as part of its model of care:

   a. **Description of the Population(s) and Specialized Services**. The MCP's model of care shall include a comprehensive description of the MCP's population and the specialized services and resources tailored to the population, and address the following components:

      i. **Risk Stratification Levels**. The MCP shall develop a risk stratification level framework for the purpose of targeting interventions and allocating resources based on the member's needs. Using a risk stratification framework comprised of five levels (i.e., from lowest to highest: monitoring, low, medium, high, and intensive), the MCP shall determine the appropriate risk stratification level for each member based on assessed needs.

         The MCP shall identify the factors to be considered when determining a member's risk stratification level. At a minimum, the MCP shall consider the following current and historical factors: acuity of chronic conditions, substance use and/or mental health disorders, maternal risk (e.g., prior preterm birth), inpatient or emergency department utilization, social determinants of health and/or safety risk factors. The MCP shall develop criteria and thresholds for each level that will be used to determine assignment to the risk stratification level.

         For all new members, within 90 calendar days of enrollment, the MCP shall use the ODM-standardized health risk assessment tool for the purpose of risk stratification and to identify potential needs for care management. The MCP shall use the standardized risk assessment tool for all members no later than July 1, 2020. The MCP shall repeat the health risk assessment annually but no later than three hundred sixty-five days of the last health risk assessment completion date.

For members newly enrolled with the MCP, an initial risk stratification level shall be assigned within the first month of the member's enrollment. The MCP shall evaluate a member's stratification level when there is a significant change in the member's needs or circumstances, progress in meeting care plan goals, etc. If the member's stratification level is changed as a result of this evaluation, the MCP shall document the facts which led to the change.

ii. **Population Stream**. Five population streams (women's health, behavioral health, chronic conditions, healthy children, and healthy adults) shall be used to organize work around population health. The MCP shall develop a strategy that assigns each member one of these population streams and corresponding hierarchy in alignment with ODM's Quality Strategy (i.e., tracking to specific population health outcomes). The MCP shall have a process to identify and track the population stream assigned to each member.

The MCP shall provide a description for each population stream that shall include the incidence and prevalence of medical and behavioral health conditions and issues that might impact health status such as age, gender, race, ethnicity, geography, language, or other socio-economic barriers that might affect the effective provision of health care services, as well as living or caregiver arrangements that might pose challenges for certain members.

iii. **Specialized Services and Resources**. The MCP's model of care shall include a description of specialized services and other resources (e.g., health and wellness programs, 24/7 nurse advice line, care management, etc.) for each population stream tailored to risk level and communities.

ODM may provide structured guidance for priority population streams that the MCP should integrate into the model of care (e.g., Ohio Department of Medicaid's Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services).

b. **Care Management**. The MCP shall ensure members are able to access care management services when needed. There shall be a clear delineation of roles and responsibilities between the MCP and other entities (CPC practice, PCMH, community partners, etc.) responsible for, or are contributing, to care management in order to ensure no duplication of, or gaps in, services. If no other accountable entity has been identified for the member, then the MCP is responsible for providing the full scope of care management services to the member.

The MCP's approach to care management shall emulate the features of a high-performing care management system: person and family centeredness; timely, proactive planned communication and action; the promotion self-care and independence; emphasis on cross continuum and system collaboration (e.g., behavioral health); and the comprehensive consideration of physical, behavioral, and social determinants of health. The MCP shall consider the Case Management Society of America's *Standards of Practice for Case Management,* 2016 when designing and implementing its care management program.

The following components shall be addressed in the care management section of the model of care:

i. **Assessment**. The MCP shall have a clear description of the process for conducting or arranging for assessments appropriate for their members' unique circumstances and needs (e.g., physical, behavioral, social, and safety) that includes the following:

1. Methods utilized to complete assessments, including any variances by risk level.

2. Timeline to complete assessments, including any variances by risk level.

3. Identification of the trigger(s) for completion of a comprehensive assessment, a disease-specific assessment or a re-assessment when there is a change to the member's health status or needs, a significant change event, a change in diagnosis, or as requested by member or his/her provider.

4. How the assessment will be used to develop and update the care plan and confirm the risk stratification level for each member.

5. How data from the member's primary care provider will be used to prevent duplication of assessment efforts and to assist with identification of priorities for the member.

6. How members who cannot be reached or who refuse assessments will be handled by the MCP, including multiple contacts if initial contacts are unsuccessful.

7. How assessment data will be stored and made available to members of the multi-disciplinary care team in order to coordinate care.

8. How assessment data will be shared with the member's other payer, as applicable, in order to prevent duplication of efforts.

ii. **Individualized Care Plans**. The MCP shall have a person-centered care planning process that includes the following components:

1. How an individualized care plan will be developed and updated based on the most recent assessment along with timelines for the initial development and updates.

2. Inclusion of prioritized measurable goals, interventions, and outcomes.

3. Development of goals with, and agreement by, the member.

4. Alignment of care plan goals with the priority issues identified by the primary care provider so the MCP can support the provider-patient relationship.

5. Validation that services recommended were received by the member and a provision that if services were not received there is necessary action taken to

address and close gaps in care.

6. Updates to the care that occur at least every 12 months or when the member's needs change significantly.

7. Retention of the ICP and making it available to members of the multi-disciplinary team.

iii. **Care Management Staffing**. The MCP staffing model shall address the following components:

i. How the MCP identifies and determines who will be the accountable point of contact (e.g., care manager);

ii. How the MCP determines the composition of the multi-disciplinary team, as needed, when the member's physical, psychosocial, and/or behavioral conditions would benefit from a range of disciplines with different but complementary skills, knowledge, and experience working together to deliver a comprehensive, integrated approach to care management;

iii. The delineation of roles and responsibilities of the team members (with particular emphasis on non-duplication of activities performed by PCPs, PCMHs, etc.);

iv. How the MCP exchanges member information within and across the team;

v. How the MCP will ensure staff who are completing care management functions are operating within their professional scope of practice, are appropriate for the member's health care needs, and follow the state's licensure/credentialing requirements.

vi. A staff training model that includes the onboarding of new employees and ongoing training for current employees on the MCP's model of care, cultural competency, person centered care planning, motivational interviewing, grievance reporting process/procedure, availability of community resources in the care manager's respective geographic areas, care management strategies for disease specific processes, abuse/neglect/exploitation reporting requirements, and HIPAA;

vii. How the MCP will strive for a single point of care management for each member in order to reduce duplication and gaps in services.

viii. That the MCP will attest that care managers and MCP employed/delegated members of the care management team are not related by blood or marriage to the member or any paid caregiver, financially responsible for the member, or empowered to make financial or health related decisions on behalf of a

member.

ix. A methodology for assigning consistent and appropriate caseloads for care managers that ensures health, welfare, and safety for members. The caseload assignment methodology shall consider the following factors: population; acuity status mix; care manager qualifications, years of experience, and responsibilities; provision of support staff; location of care manager (community, MCP office, provider office);geographic proximity of care manager to members (if community based); and access to and capabilities of technology/IT systems.

iv. **Contact Schedule**. The MCP shall establish a contact schedule with the member based on his or her needs and facilitates ongoing communication with the member. When a gap in care and/or a need for follow-up is identified, the MCP shall take action (e.g., close the gap in care, arrange transportation, referral to disease management, referral to behavioral health, etc.) and update the care plan, as appropriate.

v. **Special Populations.** The MCP shall assess special populations identified by ODM (e.g., children with special health care needs who are not affiliated with an accountable care management entity, children in custody, justice involved, etc.) to determine if there is a need for care management. The MCP shall adhere to the care coordination requirements for children in custody in accordance with ODM's *Guidance for Children in Custody* with anticipated implementation in calendar year 2020.

vi. **Care Management Status Indicators**. A care management status will be assigned to each member who is care managed by the MCP regardless of stratification level: outreach and coordination, engaged, and inactive. A member shall only be assigned to one care management status and they are defined as follows:

1. **Outreach and coordination**. This indicator is used when the MCP performs one or more of the following activities for a member: conducts outreach; educates the member; makes referrals for physical, behavioral, or social services; or provides service coordination (defined as a planned, active interaction between the MCP and any provider involved with the member).

2. **Engaged**. A member is classified as engaged after the MCP completes an assessment and develops an individualized care plan. Ongoing, the engaged status can be used when the MCP is able to meet the frequency requirements for the member's contact schedule.

3. **Inactive**. A member is regarded as inactive if the MCP has assigned a population stream and risk level but is unable to engage the member in care management and/or is not performing outreach and coordination activities for the member.

vii. **Care Management Information Technology System**. The MCP shall have a care management system that captures, at a minimum, the results of the assessment and the care plan content, including goals, interventions, outcomes, and completion dates.

Members of the care management team who use the care management system shall also have access to, and meaningfully use, relevant data about the member (claims, prior authorization data) in order to coordinate and communicate care needs across providers and delivery systems. The MCP shall use information technology systems and processes to integrate the following data elements: enrollment data, care management data, claims, member services, 24/7 nurse advice line, prior authorization data, etc. in order to maximize internal MCP communications (e.g., the Utilization Management reviewer is able to see the care management risk level and the name of a care manager for a member) about a specific member. The MCP's system shall also have capability to make care management data available to the member, the PCP and specialists.

viii. **Care Management Program Effectiveness.** ODM will implement a number of methods to evaluate the effectiveness of the MCP's care management program including a provider and consumer satisfaction survey, conducting targeted administrative performance reviews, and/or calculating results for efficiency or fragmentation of care measures.

c. **Care Transitions**. The MCP shall effectively and comprehensively manage transitions of care between both physical and behavioral health settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The MCP shall:

i. Identify members who require assistance transitioning between settings;

ii. Develop a method for evaluating risk of readmission in order to determine the intensity of follow up required for the member after the date of discharge;

iii. Designate MCP staff who will communicate with the discharging facility and inform the facility of the MCP's designated contacts;

iv. Ensure timely notification and receipt of admission dates, discharge dates, and clinical information is communicated between MCP departments, care settings, and with the primary care provider, as appropriate;

v. Participate in discharge planning activity with the facility including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCP;

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 the member's primary provider to ensure post discharge services have been provided.

When the MCP is contacted by an inpatient facility with a request to participate in discharge planning, the MCP shall cooperate as outlined above to ensure a safe discharge placement and services are arranged for the member.

d. **Enhanced Maternal Care.** The MCP shall integrate ODM's *Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services* into its model of care.

e. **Data Submission**. The MCP shall submit four electronic files as follows:

i. **Population stream**. The MCP shall submit to ODM a file that contains a population stream for all specified members. The assigned population stream shall align with ODM's five population streams: women's health, behavioral health, chronic condition, healthy children, and healthy adults. Requirements for this file submission are specified in Medicaid Managed Care: Population Stream Data Submission Specifications.

ii. **Risk Stratification Level**. The MCP shall submit a file to ODM that contains a risk stratification level for all specified members. The assigned risk stratification level will be intensive, high, medium, low or monitoring. Requirements for this file submission are specified in Medicaid Managed Care: Risk Stratification Data Submission Specifications.

iii. **Care Management Status**. The MCP 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, inactive. Requirements for this file submission are specified in Medicaid Managed Care: Care Management Status Submission Specifications.

iv. **Health Risk Assessment**. The MCP shall submit a file to ODM that contains health risk assessment results for all specified members. Requirements for this file submission are specified in Medicaid Managed Care: Health Risk Assessment Submission Specifications.

Submissions to ODM will occur quarterly and in accordance with the specifications referenced in 1.b.i-iv.

ODM, or its designee, may validate the accuracy of the information contained in the four electronic files with the MCP's records for the member.

f. **Program Evaluation**. The MCP shall assess and enhance specialized programming for each group identified by the MCP's population health management strategy using continuous quality improvement principles.

2. **Member Safeguards**. The MCP shall develop and implement safeguards, systems, and processes that detect, prevent, and mitigate harm and/or risk factors that could impact an individual's health, welfare, and safety. When the MCP 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.

a. When the member poses or continues to pose a risk to his or her health, safety, and welfare, the MCP may develop and implement a health and safety action plan between the MCP, the

member and/or the legal guardian, as applicable, identifying the risks and setting forth interventions recommended by the MCP to remedy risks to the individual's health, safety, and welfare. The MCP'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" document. The MCP shall also document in the clinical record the member's health and safety action plan, any refusal of the member to sign the health and safety action plan, and/or lack of adherence by the member to the agreed upon actions or interventions.

b. 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.

c. Once the MCP is notified by ODM or otherwise becomes aware of a current or planned loss of provider who delivers ongoing services to its members, the MCP shall immediately identify any members being served by that provider and ensure that all health and safety needs are met (e.g., securing informal support, etc.). The MCP shall assist the member with selecting a new provider as expeditiously as possible and ensure documentation is reflective of the member's choice of MCP-contracted service providers.

3. **Partnering with Payment Innovation Comprehensive Primary Care (CPC) Practices to Improve Population Health.** The MCP shall play a key role in supporting the CPC practice with achieving optimal population-level health outcomes. The MCP shall establish a relationship with each CPC practice and work collaboratively with the CPC to determine the initial and ongoing level of support to be provided by the MCP based on the CPC practice's infrastructure, capabilities, and preferences for MCP assistance (e.g., addressing social determinants of health, data sharing, etc.). Based upon this determination, the MCP shall support each of the CPC activities and the overall initiative:

For each of the following CPC activities,	the MCP shall do the following with all contracted CPC practices on a performance year basis:
24/7 and Same day appointments	• Identify and document how the CPC practice offers same day appointments (e.g., extended weekday hours, weekend hours, etc.) and offers 24/7 access to care in order to ensure accurate information and appropriate guidance is provided by member facing departments to attributed members.
Risk Stratification	• Review the risk stratified practice-attribution list (developed by the CPC practice) with the CPC practice and provide additional and/or recent data for high priority patients identified by the CPC in order to assist the CPC practice with developing and assigning practice defined patient risk stratification levels as well as ongoing care management responsibilities. • Timely notify the CPC practice of significant change events (Inpatient (IP) hospitalizations, Emergency Department (ED) visits, etc.) that could impact the assigned risk stratification level. • Update the MCP's care management system to reflect changes to the risk stratification level initiated and communicated by the CPC practice.

For each of the following CPC activities,	the MCP shall do the following with all contracted CPC practices on a performance year basis:
Population Health Management	• Provide information about MCP -administered specialized services and resources as part of the MCP's model of care for which a CPC practice can refer and link members to with assistance by the MCP. • Assist with identification of preventive or chronic services that members have not received in order to identify gaps in care. • Assist in coordinating services as needed (e.g., schedule appointments, arrange transportation, facilitate referrals and linkages to MCP health and wellness programs, etc.) in order to assist with improving health outcomes. • Share timely, meaningful, actionable data with the CPC practice that can facilitate population health activities.
Team based care delivery	• Work with each CPC practice to delineate roles and responsibilities between the CPC and the MCP for high priority patients to ensure there are no gaps in or duplication of services. • Support CPC practice's member outreach efforts, when requested. • Participate in CPC-led patient care team meetings, when requested. • Identify integrated care providers within a CPC practice and assist CPC with linking members to those providers as needed (e.g., pharmacists, dentists, behavioral health specialists)
Care management plans	• Respond timely to requests from the CPC for action and follow up by the MCP (e.g., arranging transportation, performing outreach to a patient). • Receive and integrate critical CPC data elements (e.g., social determinants of health identified by the CPC) into the MCP's care management system and use the information when interacting with members. • Share timely, meaningful, actionable data with the CPC that can facilitate effective care management activities (e.g., resolution of CPC requests for MCP follow up).
Follow up after hospital discharge	• Notify the CPC of ED visits or IP admissions for high priority patients. • Participate in discharge planning activities with the CPC and inpatient facility in order to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and/or adverse outcomes. • Support the post discharge services as specified in the discharge/transition plan. • Facilitate clinical hand offs, upon request from the CPC, between the discharging facility and other providers (e.g., home health, community behavioral health agencies). • Share timely, meaningful, and actionable data with the CPC that can facilitate effective care transitions.
Tracking of follow up tests and specialist referrals	• When requested assist with bi-directional communication between the CPC and specialists, pharmacies, labs, and imaging facilities, as needed, in order to facilitate timely exchange of information.

For each of the following CPC activities,	the MCP shall do the following with all contracted CPC practices on a performance year basis:
	• Share timely, meaningful, and actionable data with the CPC that can facilitate tracking and follow up of tests and referrals (e.g., when patients self-refer).
Patient Experience	• Facilitate a warm hand off between the MCP care manager and the CPC when care management responsibility transitions from the MCP to the CPC. • Provide quantitative or qualitative data with the CPC that can improve the patient experience (e.g., results from the MCP's member advisory groups, member satisfaction surveys, grievances and complaints, member preferences, etc.). • Participate in the CPC's improvement opportunities, as requested, aimed at improving overall patient experience and reducing disparities in patient experience.

Additional information about CPC can be found in OAC rules 5160-1-71 and 5160-1-72. The MCP shall perform the following activities in support of the CPC initiative:

a. For each practice, the MCP will designate a specific point of contact to clearly identify who will participate in CPC-led patient care team meetings and assist the CPC with effectively and efficiently navigating MCP processes (e.g., facilitating prior authorizations).

b. Work with the CPC practice to identify which members the MCP can assist with contacting.

c. Submit the CPC member attribution files as specified by ODM to meet data quality assurance standards described in the CPC Attribution File Submission Specifications and Standards Methodology.

d. Generate and provide a list of attributed members for each CPC practice.

e. Track members who are attributed to each CPC practice.

f. Reimburse CPC practices the agreed upon 'per member per month' (PMPM) payment for attributed members and any shared savings for meeting model requirements in accordance with requirements set forth by ODM. The MCP shall send the PMPM payment to CPC practices within 15 business days of receipt from ODM, unless otherwise specified by ODM. The MCP shall send the shared savings payment to CPC practices within 90 calendar days of receipt of the shared savings payment file from ODM, unless otherwise specified by ODM.

g. Reconcile payment data for each CPC practice.

h. Amend contracts, as necessary, with CPC practices to reflect the reimbursement of the PMPM payment and the shared savings payment.

i. Provide technical support, as needed, to the CPC practice to assist with its understanding and use of data files provided by the MCP.

j. Receive and integrate data provided by the CPC practice and implement throughout the MCP's systems and operations;

k. Integrate results from CPC metrics into the MCP's overall quality improvement program.

l. Use regional and community population health priorities to develop a clear improvement strategy in partnership with CPC practices.

m. Ensure provider- and member-facing departments (provider services, member services or 24/7 nurse advice lines, utilization management) are able to identify when a member is attributed to a CPC practice and use related information (e.g., the attributed CPC, expanded access offered by the CPC, explanation of why a member was attributed to a CPC, etc.) when interacting with members and providers.

4. **Partnering with Qualified Behavioral Health Entities (QBHEs) to Improve Population Health.** MCP members who are attributed to a QBHE pursuant to OAC rule 5160-1-73 shall receive all of their behavioral health care coordination (BHCC) needs from the QBHE. Unless the QBHE is unable to engage a member after attribution, the QBHE shall be the member's primary entity for managing behavioral health needs and will coordinate with the member's comprehensive primary care practice or primary care provider to ensure a comprehensive, integrated approach to managing the member's needs. If a QBHE is unable to engage a member after attribution, the MCP may choose to care manage the member until the QBHE is able to successfully engage the member, or the MCP may request ODM attribute the member to a different QBHE.

   a. The effective date of the BHCC initiative will be no earlier than July 1, 2021. Each MCP will be required to perform administrative activities as per the following:

      i. Contract with all ODM-approved QBHEs within 90 calendar days of the approved application date, except when there are documented instances of quality concerns.

      ii. Implement system edits that are consistent with ODM's policy for the provision and payment of behavioral health services for attributed members as follows:

         1. Payments for community supportive psychiatric treatment and case management as described in OAC rule 5160-27-02 will not be made as these are considered duplicative of BHCC program activities.

         2. For attributed members who are also receiving substance use disorder (SUD) residential treatment, the following applies:

            - The eligible member will be attributed to or maintain attribution with a QBHE during the SUD residential treatment period.

b. The QBHE may bill the full monthly BHCC payments if the QBHE performed minimum required activities before the beginning of the SUD residential treatment or after an attributed member is no longer receiving SUD residential treatment. The QBHE will not be eligible for BHCC payments during the eligible member's SUD residential treatment period because BHCC is duplicative of the care coordination responsibilities of the SUD residential treatment program.

c. The QBHE will immediately re-engage the eligible member for BHCC upon discharge from the SUD residential treatment period.

3. For eligible members who also meet criteria for assertive community treatment (ACT) as defined in OAC Chapter 5160-27, the following applies:

   a. The eligible member will be attributed to or maintain attribution with a QBHE.

   b. ACT is required to begin on the 1st calendar day of the month.

   c. If the QBHE is certified to deliver ACT, it shall provide ACT in lieu of BHCC as long as ACT is medically necessary. When the ACT service is no longer medically necessary, the eligible member shall be transitioned to BHCC.

   d. If the QBHE is not an eligible provider of ACT, the eligible member may choose to either receive BHCC from the QBHE or opt-out and receive ACT from a provider eligible to deliver ACT. In addition, the QBHE may bill the full monthly BHCC payment after the member is no longer receiving ACT and the QBHE delivered the minimum required activities.

4. For eligible members who also meet criteria for intensive home-based treatment (IHBT) as defined in OAC Chapter 5160-27, the following applies:

   a. The eligible member will be attributed to or maintain attribution with a QBHE.

   b. If the QBHE is certified to deliver IHBT, it shall provide IHBT in lieu of BHCC as long as IHBT is medically necessary. When IHBT is no longer medically necessary, the eligible member shall be transitioned to BHCC.

   c. If the QBHE is not an eligible provider of IHBT, the QBHE may bill the full monthly BHCC payment if the QBHE delivers minimum required activities before the beginning of IHBT treatment or after the attributed member is no longer receiving IHBT.

iii. Implement a process to validate target member and attribution files provided by ODM to the MCP.

iv. Implement a process to receive requests from a provider for a member identified outside of the attribution and make a determination of BHCC service eligibility in accordance with OAC rule 5160-26-03.1. As part of this process, the MCP will work with the other MCPs to develop a standardized prior authorization form for use by providers.

b. Upon full implementation of the BHCC initiative, the MCP shall play a key role in supporting the QBHEs with achieving optimal population level health outcomes. At a minimum, the MCP shall support each of the behavioral health care coordination activities and the overall initiative:

For each of the following BHCC activities,	The MCP shall have the following roles and responsibilities to support BHCC and QBHEs
Initial outreach/engagement	• Educate members and caregivers/families about the program and benefits of program participation. • Process referrals from providers in order to determine program eligibility.
Comprehensive care plan	• Participate in QBHE-led patient care team meetings, when requested. • Respond timely to requests from QBHE for action and follow up by the MCP (e.g., arranging transportation, performing outreach to a patient) • Receive and integrate critical QBHE data elements into the MCP's care management system and use the information when interacting with members and/or providers. • Share timely, meaningful, actionable data with the QBHE that facilitates effective person centered care planning activities.
Ongoing engagement and relationship	• Designate a single point of contact for the QBHE. • Work with each QBHE to delineate roles and responsibilities for high priority patients to ensure there are no gaps in or duplication of services. • Assist with outreach to members, when requested. • Assist with cross-system communication and collaboration between the QBHE and CPC practice, or PCP, or other providers, when requested.
Individual transition	• Notify the QBHE of emergency department or inpatient visits for members. • Participate in discharge planning activities, upon request, with the QBHE and inpatient facility in order to support a safe discharge placement and prevent unplanned or unnecessary readmissions, ED visits, and/or adverse outcomes. • Support the post discharge services as specified in the discharge/transition plan.

	• Assist with cross-system communication and collaboration between the QBHE and CPC practice, or PCP, or other providers, when requested. • Share timely, meaningful, and actionable data with the QBHE that facilitates effective care transitions.
Individual engagement and access to appropriate care	• Assist with addressing barriers to care, upon request. • Share timely, meaningful, and actionable data with the QBHE that facilitates access to appropriate care.
Engaging supportive services	• Provide assistance with referral and linkage to supportive services as requested by the QBHE.
Population health management	• Provide information about MCP-administered specialized services and resources as part of the MCP's model of care for which a QBHE can refer and link members to with assistance from the MCP. • Assist with identification of services that members have not received in order to address and close gaps in care. • Assist with coordinating services as needed (e.g., schedule appointments, arrange transportation, facilitate referrals and linkages to MCP health and wellness programs) in order to optimize health outcomes. • Share timely, meaningful, actionable data with the QBHE that can facilitate population health activities.

c. Upon full implementation of the BHCC initiative, the MCP shall perform the following ongoing administrative activities in support of the behavioral health care coordination initiative:

   i. Reimburse the QBHEs for performing the BHCC service at the rate specified by ODM in accordance with requirements set forth by ODM. This includes assuring that system edits are consistent with ODM's policy for the provision and payment of behavioral health services for attributed members as specified in this appendix.

   ii. Reimburse QBHEs incentive payments for meeting quality, efficiency, or total cost of care metrics in accordance with requirements set forth by ODM.

   iii. Provide technical support, as needed, to the QBHE to assist with its understanding and use of: 1) data files provided by the MCP; and 2) interacting with the MCP's portal, as specified by ODM, to obtain information about member attribution to the QBHE.

   iv. Validate target member and attribution files provided by ODM to the MCP to ensure that members are appropriately determined as eligible for the BHCC program, that those members are enrolled with the MCP for the relevant time period, and any other quality assurance needed to verify that the files contain accurate information regarding included members and attributed QBHEs.

   v. Provide ODM with a monthly add/delete file per ODM's specifications that contains information about members: 1) who have been referred and approved; 2) who have

selected or have been attributed by claims to a new QBHE; 3) who are no longer enrolled with the MCP; or 4) any other changes in status regarding a member's enrollment with a QBHE.

vi. Receive and integrate data provided by the QBHE and implement through the MCP's systems and operations.

vii. Integrate results from the QBHE metrics into the MCP's overall quality improvement program.

viii. Evaluate regional and community population health priorities to develop a clear improvement strategy in partnership with the QBHE.

ix. Ensure member and provider facing departments (provider services, member services or nurse advice lines, utilization management) are able to identify when a member is attributed to a QBHE and use related information when interacting with members and providers.

5. **Coordination and Collaboration with Care Management Entities.**

- The MCP shall coordinate a member's care with entities that:

i. Provide case management services to managed care members who receive services from any of the following Medicaid waiver programs: Ohio Home Care waiver, PASSPORT waiver, Assisted Living waiver, and DODD-administered waivers.

ii. Provide recovery management services to individuals eligible for Specialized Recovery Services under OAC Chapter 5160-43.

iii. Provide services through HOME Choice, as applicable. The MCP shall support these agencies per the following:

b. The MCP shall collaborate with these entities by:

i. Delineating responsibilities between the agency and the MCP in order to avoid duplication or gaps in services.

ii. Maintaining a single point of contact for the agency.

iii. Transmission of requested data, information, and reports in a timely manner.

iv. Responding to requests for assistance or support in a timely manner.

c. The MCP shall comply with the coordination and continuity of care requirements found in 438.208(b) for all members.

6. **Maternal and Infant Support Program (MISP)** The MCP shall actively participate, as directed by ODM, in ODM's efforts to design and implement a Maternal and Infant Support Program that will be implemented no earlier than January 1, 2021. The MCP shall implement system edits to support payment of new MISP providers and services that shall be fully functional as of January 1, 2021.

7. **Coordination and Collaboration for Justice-Involved Individuals.**

    a. **Transition of Care from the Ohio Department of Rehabilitation and Correction's Facilities to the Community for Critical Risk Individuals.** The MCP shall facilitate and manage transitions of care for pending members who are designated as "critical risk" (refer to ODM's Methodology for Identification of Critical Risk Individuals) and are being discharged from Ohio Department of Rehabilitation and Correction's (ODRC)'s facilities.

        i. Upon receiving notification from ODM and/or ODRC about pending members who will be released from the ODRC facility and will be enrolled with the MCP, the MCP shall identify which pending members meet the critical risk criteria. For pending members confirmed as meeting the critical risk criteria, the MCP will receive clinical information from ODRC and other entities. The MCP may request additional information for these pending members from the ODRC facility using the process prescribed by ODM. The MCP shall notify ODRC if the requested records are not received within the timeframes established by ODRC & ODM.

        ii. The MCP shall develop a transition plan for pending members using the approved ODM form with information provided by ODRC and other programs/entities (e.g., Ohio Department of Mental Health and Addiction Services' Community Linkages program). The MCP shall facilitate input to the transition plan by entities specified by ODM. The MCP will conduct an interactive session (e.g., videoconference) to review the completed transition plan with each pending member who meets the critical risk criteria. The MCP will request the interactive session and submit a copy of the transition plan to the ODRC facility according to the methods and timeframes prescribed by ODM. The MCP shall make reasonable effort to conduct this interactive session at least 14 calendar days prior to the pending member's scheduled release date from the ODRC facility. The MCP shall review the transition plan with the pending member during the interactive session and identify/confirm necessary changes that will be made to the transition plan. The MCP shall update the transition plan, as appropriate, and submit the final transition plan to ODRC/Operations Support Center and the ODRC facility as prescribed by ODM.

        iii. After the pending member is released from the ODRC facility, the MCP shall contact the member as expeditiously as the member's condition warrants but not later than five calendar days from the date of release to assist the member with accessing care according to the transition plan, including identifying and removing barriers to care, and addressing additional needs expressed by the member. If the MCP is unable to contact the member within the first five calendar days (by making three different attempts over the 5 days), the MCP shall send a letter to the member no later than seven calendar days from the release date. The letter shall include contact information for member services and the care management department the member can use to request assistance with accessing services or community supports. The MCP shall document all

outreach attempts and contacts with the member.

iv. The MCP shall assess the member's need for care management using processes established in this appendix.

v. The MCP will support members participating in the Medication Assisted Treatment (MAT) Program through collaboration and communication with ODRC, OMHAS, community providers, etc. as specified by ODM.

b. **Addiction Treatment Program (ATP).** The MCP shall cooperate with ODM's efforts to support the Ohio Department of Mental Health and Addiction Services' implementation of the Addiction Treatment Program, a specialized docket program in select counties providing addiction treatment to individuals who are eligible to participate in medication assisted treatment drug court because of their dependence on opioids, alcohol or both. ODM will inform the MCP of the participating ATP drug courts. ATP drug courts will access MITS to identify the drug court participant's MCP and transmit member level identifying information via secure transmission to the MCP's designated ATP contact. An MCP may also receive notification from a treatment provider or another source. Upon receiving notification of a member's participation in an ATP drug court, the MCP shall timely remove prior authorization or step therapy for medication-assisted treatment, including long-acting injectable antagonist therapies, partial agonist therapies, and full agonist therapies, for program participants. The MCP shall ensure the timely provision of all medically necessary treatment services, including medication assisted treatment, in accordance with the member's plan of care and coordinate any services and supports needed by the member in his/her treatment recovery. The MCP shall also assess care management needs for each member participating in ATP. Upon learning of a member's completion of the ATP program, the MCP shall assist the member with transitioning to other recovery services and supports as appropriate.

8. **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 systematic methods for discovering reliable approaches to improving population health. Consistent with this definition, the MCP 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.

   In accordance with 42 CFR 438.330, the MCP shall establish and implement an ongoing comprehensive QAPI program for the services it delivers to its members. Updates to the MCP's QI program shall be submitted to ODM annually within the QAPI template and shall include the following elements:

   a. **QI Program Structure.** The MCP's quality improvement efforts shall be integrated throughout the organization so that: (1) staff at all levels of the organization are 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, as well as externally in order to foster a culture of innovation, and (3) staff across all levels of the organization are empowered to seek out the root cause of problems and collaboratively test improvement strategies in order to rapidly learn what works and maintain and spread successes.

The MCP 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, etc.) 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 so that QI activities are regularly assessed and lessons are learned from failures and successes; assurance that the Medical Director is involved in all clinically-related projects; and a commitment to providing staff at all levels of 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 MCP's senior-level QI leadership team shall provide 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 MCP 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 MCP'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 MCP 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 learn from improvement initiatives to maximize successes, and transparently sharing quality improvement opportunities and the results of quality improvement initiatives throughout the organization and with ODM.

The senior level QI leadership team structure shall 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 MCP shall have established an ODM-approved, senior leadership QI structure that is responsible for ensuring on-going, rapid-cycle improvement of the quality of care and services and championing improvement efforts through 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 MCP 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 maintenance and spread of effective efforts.

i. **Quality Improvement Teams.** Quality improvement teams shall be composed of MCP 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. MCP policies and processes related to the improvement topic.

Team members shall be empowered to test and promote improved MCP operations, as illustrated by at least one member of each improvement team having decision-making authority for testing and evaluating changes to plan processes.

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 a direct contact for physician and/or member partners. Direct contacts for physician or member partners in the QI effort help ensure that 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 analysis to quickly determine the effectiveness of interventions.

2. Use of data to identify improvement opportunities, as well as longitudinal data monitoring and analysis 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 MCP staff, improvement project team members, and the senior leadership team regarding the status of improvement projects, intervention successes and failures, data used to determine success, 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 MCP 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, MCP Medical Directors, Quality Improvement Directors, analytic support staff, and at least one MCP staff person assigned to each improvement team shall complete training, from an ODM-approved entity, which includes the active application of rapid cycle quality improvement tools and methods. The MCP'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 Appendix C.

i. **QI Training Content**. Content shall include, but not be limited to:

1. The Model for Improvement developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI),

2. Edward W. Deming's System of Profound Knowledge,

3. Listening to and incorporating the Voice of the Customer (VOC),

4. Process mapping/flow charting,

5. SMART Aim development and the use of key driver diagrams[1] for building testable hypotheses,

6. Methods for barrier identification and intervention selection (e.g., root cause analyses, Pareto charts, failure mode and effects analysis, the 5 whys technique, etc.),

7. Selection and use of process, outcome, and balancing measures,

8. Testing change through the use of PDSA cycles,

9. The use of statistical process control, such as the Shewart control chart, and

10. Tools for spread and sustainability planning.

ii. **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).

iii. **Applying QI Training Concepts**. During and subsequent to quality improvement training, MCP 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 MCP. 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, 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).

iv. **QI Training Exemptions**. MCP 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.

v. **ODM Funded QI Training Efforts.** MCP staff at all levels of the organization shall be required to actively 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 classes and QI meetings, and applying learned concepts to current MCP improvement projects.

e. **MCP Quality Improvement Strategy**. The MCP 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 MCP's quality improvement strategy shall, at minimum, describe:

i. The MCP leadership team, including leadership positions and how each role supports and champions the MCP's quality improvement strategy and related initiatives and projects;

ii. How the MCP strategy aligns with the current ODM Quality Strategy, including how the MCP will collaborate with other MCPs on ODM-directed population health efforts;

iii. The MCP's quality improvement initiatives, including:

1. How the initiative relates to other MCP initiatives, as well as to MCP and ODM quality strategies;

2. The theory of change for each improvement project (i.e., cause and effect diagrams, key driver diagrams);

3. Criteria considered when choosing and prioritizing the MCP's improvement projects and initiatives by population stream;

4. The process for identifying the root causes of prioritized improvement initiatives;

5. The process(es) for identifying and 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. Methods and data used to evaluate intervention effectiveness and a description regarding how positive and negative results contribute to lessons learned;

9. 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 MCP's quality strategy; and

10. The development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, enrollee satisfaction, and other targets of improvement efforts.

f. **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 MCP's improvement strategy, improvement projects shall be designed and implemented to build confidence among internal and external customers regarding the MCP's commitment to population health and focus on continual improvement of services and outcomes.

The MCP shall evaluate all improvement projects, interventions, and initiatives and integrate the results into its overall quality assessment and improvement program.

The MCP 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 MCPs and with ODM to improve population health planning statewide.

i. **Performance Improvement Projects**. In accordance with 42 CFR 438.330, the MCP shall conduct clinical and non-clinical performance improvement projects (PIPs) using rapid cycle quality improvement science techniques. The MCP shall initiate and complete PIPs in topics selected by ODM. All PIPs designed and implemented by the MCP shall demonstrate improvement and the MCP shall clearly articulate lessons learned during the course of the initiative. The MCP shall adhere to ODM-specified reporting, submission, and frequency guidelines during the life of the PIP, establish and implement mechanisms for rapidly testing interventions, and establish mechanisms for spreading and sustaining successful interventions in order to optimize improvement gains. Upon request, the MCP shall provide longitudinal data demonstrating sustained improvement over the course of the project and during the sustainability phase following final validation of the PIP by ODM's external quality review organization (EQRO).

The EQRO will assist the MCP 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.

ii. **Quality Improvement Projects**. Quality Improvement Projects (QIPs) use rapid cycle quality improvement science principles and may be required by the state or initiated by the MCP. Like PIPs, the QIPs can focus on clinical or non-clinical areas, are intended to achieve significant and sustained improvement over time, and have favorable effects on health outcomes, quality of life, and provider/consumer satisfaction. Although QIPs are not validated by the EQRO, the MCP shall adhere to ODM-specified reporting and submission requirements.

The MCP shall actively participate in performance and quality improvement initiatives facilitated by ODM, the EQRO, or both. This includes improvement projects focused on topics within each population stream, MCP support of CPC practices, and efforts with other state agencies, quality collaboratives, and efforts with community-based organizations impacting MCP membership. MCP participation shall also be required in ODM-directed population health efforts that require collaboration between all MCPs and may include standardization of program processes across plans.

g. **Program Communication.** Each MCP 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 across the organization and to executive leadership. Status updates shall include: lessons learned from intervention testing, advances to the theory of knowledge, and the progress on process and outcome measures;

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.

h. **Clinical Practice Guidelines.** The MCP's QAPI shall describe how the MCP will ensure that the clinical practice guidelines are valid and represent reliable clinical evidence or a consensus of healthcare professionals in a particular field. MCPs shall follow the guidance in the QAPI submission template when describing this aspect of the program.

i. **Assessment of Health Care Service Utilization**. The MCP shall have mechanisms in place to detect under- and over-utilization of health care services. The MCP 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 MCP shall ensure the utilization analysis documented in the QAPI is linked to ensuring population health outcomes, and is incorporated into the quality strategy.

Pursuant to the program integrity provisions outlined in Appendix I, the MCP 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 MCP 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.

The MCP 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.

j. **Assessment of the Quality and Appropriateness of Care for Members with Special Health Care Needs and Enrollees Receiving Long-term Services and Supports**. The MCP shall have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs and enrollees receiving long-term services and supports. The MCP shall follow the guidance in the QAPI submission template when describing and evaluating these aspects of the program.

k. **Addressing Health Disparities**. The MCP 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). To further advance ODM's efforts to achieve health equity, the MCP shall collect and meaningfully use member-identified race, ethnicity, language, and social determinants of health 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.

The MCP 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.

l. **Submission of Performance Measurement Data**. The MCP shall submit data as required by ODM that enables ODM to calculate standard measures as defined in Appendices L and M. The MCP shall also submit self-reported, audited Healthcare Effectiveness Data and Information Set (HEDIS) data (see ODM Methodology for MCP Self-Reported, HEDIS-Audited Data) for performance measures set forth in Appendix M. A separate, duplicative submission of performance measurement data is not required as part of the annual QAPI submission.

m. **QAPI Program Impact and Effectiveness**. The MCP shall evaluate the impact and effectiveness of each effort within the QAPI program, including efforts to reduce health disparities. The MCP 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 MCP's quality strategy.

9. **External Quality Review.** ODM will select an external quality review organization (EQRO) to provide for an annual external and independent review of the quality, outcomes, timeliness of, and access to services provided by the MCP. The MCP shall participate in annual external quality review which will include but not be limited to the following activities:

a. Comprehensive Administrative compliance review as required by 42 CFR 438.358 and as specified by ODM.

i. **Non-duplication Exemption.** In accordance with 42 CFR 438.360 and 438.362, an MCP with accreditation from a national organization approved by the Centers for Medicare and Medicaid services may request to be exempted (deemed) from certain portions of the administrative compliance review. ODM will inform the MCP when a non-duplication exemption may be requested.

ii. The EQRO may conduct focused reviews of MCP performance in the following domains which include, but are not limited to:

1. Availability of services;

2. Assurances of adequate capacity and services;

3. Coordination and continuity of care;

4. Coverage and authorization of services;

5. Provider selection;

6. Confidentiality;

7. Grievance and appeal systems;

8. Sub contractual relationships and delegation;

9. Practice guidelines; and

10. Health information systems

b. Encounter data studies.

c. Validation of performance measurement data.

d. Review of information systems.

e. Validation of performance improvement projects.

f. Member satisfaction and/or quality of life surveys.

The MCP shall submit data and information, including member medical records, at no cost to, and as requested by, ODM or its designee for the annual external quality review activities.

10. **Specialized Services for High Risk Populations.** The MCP may provide or arrange for specialized (or non-traditional) services to be delivered via different models in the community, including home visiting, centering, community hub, community workers, etc., as appropriate, for high risk populations identified by the MCP or ODM. The MCP is responsible for ensuring that the community services are culturally-competent, meet the member's needs, honor member preference, and do not duplicate other services paid for by the MCP and/or ODM. At a minimum, if a member is pregnant or capable of becoming pregnant, resides in a community serviced by a qualified community hub, has been recommended to receive HUB pathway services by a physician, advance practice registered nurse, physician assistant, public health nurse, or another licensed health professional specified by the MCP or ODM, the MCP shall provide for the delivery of the following services provided by a certified community health worker or public health nurse, who is employed by, or works under contract with, a qualified community hub[1]:

    a. Community health worker services or services provided by a public health nurse to promote the member's healthy pregnancy; and

    b. Care coordination performed for the purpose of ensuring that the member is linked to employment services, housing, educational services, social services, or medically necessary physical and behavioral health services.

    The MCP may require prior authorization for non-traditional services for high-risk populations.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

[1] Qualified community hub means a central clearinghouse for a network of community care coordination agencies that meets all of the following criteria: (a) demonstrates to the director of health that it uses an evidenced-based, pay-for performance community care coordination model (endorsed by the federal agency for health research and quality, the national institutes for health, and the centers for Medicare and Medicaid services or their successors) or uses certified community health workers or public health nurses to connect at-risk individuals to health, housing, transportation, employment, education and other social services; (b) is a board of health or demonstrates to the director of health that it has achieved, or is engaged in achieving certification from a national hub certification program; and (c) has a plan specifying how the board or health or community hub ensures that children served by it receive appropriate development screenings as specified in the publication titled "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents," available from the American academy of pediatrics, as well as appropriate early and periodic screening, diagnostic, and treatment services.

APPENDIX L

DATA QUALITY

The data quality standards and requirements established in this appendix will be used to determine the value of Ohio's Medicaid Managed Care Program and to evaluate Medicaid consumers' access to quality services. Data collected from the MCP 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 incentives. The data will also be used in conjunction with the cost reports in setting the premium payment rates. Data sets collected from the MCP with data quality standards and/or submission requirements include: encounter data; Healthcare Effectiveness Data and Information Set (HEDIS) data; care management data; appeals and grievances data; utilization management data; Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, third party liability data, and primary care provider data.

The measures in this appendix are calculated per MCP using statewide results that include all regions in which the MCP has membership. For detailed descriptions of the encounter data quality measures below, see *ODM Methods for the MAGI, ABD, and Adult Extension Encounter Data Quality Measures* at https://www.medicaid.ohio.gov.

ODM reserves the right to revise the measures and measurement periods established in this appendix (and their corresponding compliance periods), as needed. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's performance level for that contract period.

1. **Encounter Data.** The MCP 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**. This measure is calculated separately for ABD adults, ABD children, MAGI members (adults and children combined), and Adult Extension members.

        Measurement. The volume measure for each population and service category, as listed in Table 1 of this appendix, is the rate of utilization (e.g., admits, visits) per 1,000 member months (MM).

        Measurement Period. The measurement periods for each population for SFY2020 and SFY 2021 contract periods are listed in Table 1 below.

        Data Quality Standards. The data quality standards, per population, plan, and service category, are listed in Table 4 below. This measure is calculated separately for each population and plan. For each population, the MCP shall meet or exceed the standard for every service category, in all quarters of the measurement period. For each measure, two conditions must be met for each quarter in order for the MCP to successfully meet the standard for that quarter:

- The plan specific, category of service specific, standard of encounter data volume as listed in Table 4.

- The maximum percentage decrease of encounter data volume allowed for each MCP for each category of service per Tables 2 and 3:

  - From one quarter to the following quarter (e.g. the percentage decrease from Q1 2019 to Q2 2019).

  - From one quarter to the quarter not directly following it but two quarters later from the first quarter (e.g. the percentage decrease from Q1 2019 to Q3 2019).

Table 1. Measurement Periods for the SFY 2020 & SFY 2021 Contract Periods.
Note: Qtr 1 = January to March; Qtr 2 = April to June; Qtr 3 = July to September; Qtr 4 = October to December

MAGI Quarterly Measurement Periods	ABD Adult Quarterly Measurement Periods	ABD Child Quarterly Measurement Periods	Adult Extension Members Quarterly Measurement Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1: 2019	Qtr 1: 2019	Qtr 1: 2019	Qtr 1: 2019	November 2019	December 2019	SFY 2020
Qtr 1 thru Qtr 2: 2019	Qtr 1 thru Qtr 2: 2019	Qtr 1 thru Qtr 2: 2019	Qtr 1 thru Qtr 2: 2019	February 2019	March 2020	
Qtr 1 thru Qtr 3: 2019	Qtr 1 thru Qtr 3: 2019	Qtr 1 thru Qtr 3: 2019	Qtr 1 thru Qtr 3: 2019	May 2020	June 2020	
Qtr 1 thru Qtr 4: 2019	Qtr 1 thru Qtr 4: 2019	Qtr 1 thru Qtr 4: 2019	Qtr 1 thru Qtr 4: 2019	August 2020	September 2020	SFY 2021
Qtr 1: 2019 thru Qtr 1: 2020	Qtr 1: 2019 thru Qtr 1: 2020	Qtr 1: 2019 thru Qtr 1: 2020	Qtr 1: 2019 thru Qtr 1: 2020	November 2020	December 2020	
Qtr 1: 2019 thru Qtr 2: 2020	Qtr 1: 2019 thru Qtr 2: 2020	Qtr 1: 2019 thru Qtr 2: 2020	Qtr 1: 2019 thru Qtr 2: 2020	February 2020	March 2021	
Qtr 1: 2019 thru Qtr 3: 2020	Qtr 1: 2019 thru Qtr 3: 2020	Qtr 1: 2019 thru Qtr 3: 2020	Qtr 1: 2019 thru Qtr 3: 2020	May 2021	June 2021	

Table 2. Maximum Percent (%) Reduction for One Quarter Difference.

Quarters Included	Maximum % Reduction Allowed	Categories of Service Included
% Difference between Q1 2019 and Q2 2019 in EDV/MM	22.50%	Behavioral Health, Dental, DME, Emergency
% Difference between Q2 2019 and Q3 2019 in EDV/MM	12.50%	Behavioral Health, Dental, DME, Emergency

% Difference between Q3 2019 and Q4 2019 in EDV/MM	12.50%	Behavioral Health, Dental, DME, Emergency
% Difference between Q4 2019 and Q1 2020 in EDV/MM	12.50%	Behavioral Health, Dental, DME, Emergency
% Difference between Q1 2019 and Q2 2019 in EDV/MM	22.50%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q2 2019 and Q3 2019 in EDV/MM	12.50%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q3 2019 and Q4 2019 in EDV/MM	12.50%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q4 2019 and Q1 2020 in EDV/MM	12.50%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q1 2019 and Q2 2019 in EDV/MM	27.50%	Vision
% Difference between Q2 2019 and Q3 2019 in EDV/MM	17.50%	Vision
% Difference between Q3 2019 and Q4 2019 in EDV/MM	17.50%	Vision
% Difference between Q4 2019 and Q1 2020 in EDV/MM	17.50%	Vision
% Difference between Q1 2019 and Q2 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q2 2019 and Q3 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q3 2019 and Q4 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q4 2019 and Q1 2020 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q1 2019 and Q2 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q2 2019 and Q3 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q3 2019 and Q4 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q4 2019 and Q1 2020 in EDV/MM	No maximum % reduction	Inpatient

*Deliveries category of services only applies to CFC population

Table 3. Maximum Percent (%) Reduction for Two Quarter Difference.

Quarters Included	Maximum % Reduction Allowed	Categories of Service Included
% Difference between Q1 2019 and Q3 2019 in EDV/MM	30.00%	Behavioral Health, Dental, DME, Emergency
% Difference between Q2 2019 and Q4 2019 in EDV/MM	20.00%	Behavioral Health, Dental, DME, Emergency
% Difference between Q3 2019 and Q1 2020 in EDV/MM	20.00%	Behavioral Health, Dental, DME, Emergency
% Difference between Q4 2019 and Q2 2020 in EDV/MM	20.00%	Behavioral Health, Dental, DME, Emergency
% Difference between Q1 2019 and Q3 2019 in EDV/MM	30.00%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q2 2019 and Q4 2019 in EDV/MM	20.00%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q3 2019 and Q1 2020 in EDV/MM	20.00%	Outpatient, Pharmacy, Primary and Specialty

% Difference between Q4 2019 and Q2 2020 in EDV/MM	20.00%	Outpatient, Pharmacy, Primary and Specialty
% Difference between Q1 2019 and Q3 2019 in EDV/MM	35.00%	Vision
% Difference between Q2 2019 and Q4 2019 in EDV/MM	25.00%	Vision
% Difference between Q3 2019 and Q1 2020 in EDV/MM	25.00%	Vision
% Difference between Q4 2019 and Q2 2020 in EDV/MM	25.00%	Vision
% Difference between Q1 2019 and Q3 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q2 2019 and Q4 2019 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q3 2019 and Q1 2020 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q4 2019 and Q2 2020 in EDV/MM	No maximum % reduction	Deliveries*
% Difference between Q1 2019 and Q3 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q2 2019 and Q4 2019 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q3 2019 and Q1 2020 in EDV/MM	No maximum % reduction	Inpatient
% Difference between Q4 2019 and Q2 2020 in EDV/MM	No maximum % reduction	Inpatient

*Deliveries category of services only applies to CFC population

Table 4. Data Quality Standards Per Managed Care Plan.

Buckeye				
Category of Service	**MAGI**	**ABD Adult**	**ABD Child**	**Adult Extension**
Behavioral Health	TBD	TBD	TBD	TBD
DME	17.4	139.3	103.2	43.0
Emergency	68.4	139.2	76.0	88.3
Inpatient	1.1	17.2	5.5	6.0
Primary & Specialist Care	318.2	816.7	420.7	481.0
Outpatient	73.1	152.4	171.0	89.0
Pharmacy	629.2	4276.1	950.6	1719.7
Dental	60.2	43.0	50.7	50.4
Vision	18.4	26.3	21.7	20.3
Deliveries	2.8	N/A	N/A	N/A

CareSource				
Category of Service	**MAGI**	**ABD Adult**	**ABD Child**	**Adult Extension**
Behavioral Health	TBD	TBD	TBD	TBD
DME	25.8	164.9	116.0	56.0
Emergency	67.3	144.7	70.3	89.8
Inpatient	1.2	19.3	5.1	6.9
Primary & Specialist Care	357.2	978.5	469.4	588.6
Outpatient	85.0	160.1	162.2	102.2
Pharmacy	854.8	5804.7	1469.4	2518.9
Dental	76.7	48.1	55.3	63.4

Vision	23.2	34.4	30.2	27.5
Deliveries	2.5	N/A	N/A	N/A

Molina				
Category of Service	**MAGI**	**ABD Adult**	**ABD Child**	**Adult Extension**
Behavioral Health	TBD	TBD	TBD	TBD
DME	18.7	148.3	125.2	41.8
Emergency	68.8	132.4	74.0	88.6
Inpatient	1.1	16.3	6.0	6.1
Primary & Specialist Care	322.9	887.2	460.9	484.1
Outpatient	79.4	138.9	205.8	85.5
Pharmacy	681.0	4980.6	1322.0	1784.8
Dental	65.4	39.1	53.3	46.7
Vision	20.3	29.6	24.8	21.7
Deliveries	2.4	N/A	N/A	N/A

Paramount				
Category of Service	**MAGI**	**ABD Adult**	**ABD Child**	**Adult Extension**
Behavioral Health	TBD	TBD	TBD	TBD
DME	22.8	122.3	128.7	41.0
Emergency	69.1	157.8	69.6	92.1
Inpatient	1.5	19.0	5.7	7.4
Primary & Specialist Care	347.6	853.6	451.7	493.8
Outpatient	53.8	131.4	140.4	83.7
Pharmacy	711.7	3862.7	1256.2	1789.2
Dental	53.7	41.3	47.7	43.2
Vision	20.3	26.4	26.3	19.1
Deliveries	3.1	N/A	N/A	N/A

United				
Category of Service	**MAGI**	**ABD Adult**	**ABD Child**	**Adult Extension**
Behavioral Health	TBD	TBD	TBD	TBD
DME	17.3	139.1	97.1	44.4
Emergency	66.3	138.7	73.3	86.3
Inpatient	0.9	13.4	3.5	5.3
Primary & Specialist Care	316.2	852.3	421.1	519.7
Outpatient	79.5	136.4	160.6	98.1
Pharmacy	666.2	4439.5	1241.1	1951.9
Dental	60.1	44.8	52.4	51.4
Vision	19.2	29.4	23.1	23.7
Deliveries	2.4	N/A	N/A	N/A

ii. **Incomplete Billing Provider Data.** This measure is calculated to ensure providers reported on encounters can be associated with Medicaid and/or Reporting providers in MITS.

Measure. The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data field that do not have a NPI and Medicaid or Reporting Provider Number in MITS.

Measurement Period. The measurement periods for the SFY 2020 and SFY 2021 contract periods are listed in Table 5 above. The MCP shall meet or exceed the standard in all quarters of the measurement period.

Data Quality Standard. Less than or equal to **2.0%.**

iii. **Incomplete Rendering Provider Data.** This measure is calculated to ensure the MCP is reporting individual-level rendering provider information to ODM so that Ohio Medicaid complies with federal reporting requirements.

Measure. The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in MITS.

Measurement Period. The measurement periods for the SFY 2020 and SFY 2021 contract periods are listed in Table 5 below. The MCP shall meet or exceed the standard in all quarters of the measurement period.

Data Quality Standard. Less than or equal to **4.0%.**

Table 5. Measurement Periods for the 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 2: 2017 thru Qtr 1: 2019	December 2019	January 2020	SFY 2020
Qtr 3: 2017 thru Qtr 2: 2019	February 2020	March 2020	
Qtr 4: 2017 thru Qtr 3: 2019	March 2020	June 2020	
Qtr 1: 2018 thru Qtr 4: 2019	August 2020	September 2020	SFY 2021
Qtr 2: 2018 thru Qtr 1: 2020	November 2020	December 2020	
Qtr 3: 2018 thru Qtr 2: 2020	February 2020	March 2021	
Qtr 4: 2018 thru Qtr 3: 2020	May 2021	June 2021	

Note: Qtr 1 = January-March; Qtr 2 = April-June; Qtr 3 = July-September; Qtr 4 = October-December

iv. **National Provider Identifier (NPI) for Ordering, Referring, and Prescribing (ORP) Providers.** The MCP must require an ordering, referring, or prescribing 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 MCP and includes all members receiving services from the MCP.

Measure. Percentage of EDI transactions with qualifying billing provider types and specialties with an NPI provider number in the ordering/referring/prescribing 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 Therapy.

Measurement Period. The reporting periods for the current contract period are listed in Table 6 below. Results for CY2019 will be informational only. Results for CY2019 will be used to set a baseline for CY2020. This measure will be used for informational purposes until given further notice.

Table 6. Measurement Periods for the 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	
Qtr 1 2020	TBD	TBD	SFY 2021
Qtr 1 thru Qtr 2 2020	TBD	TBD	
Qtr 1 thru Qtr 3 2020	TBD	TBD	
Qtr 1 thru Qtr 4 2020	TBD	TBD	

Data Quality Standard. To be determined.

v. **Rejected Encounters.** Encounters submitted to ODM that are incomplete or inaccurate are rejected and reported back to the MCPs on the exception report. The MCP must resubmit rejected encounters to ODM.

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.

Measure The percentage of encounters submitted to ODM that are rejected.

Measurement Period. For the SFY 2020 contract period, performance will be evaluated using the following measurement periods: July – September 2019; October – December 2019; January – March 2020; and April – June 2020.

Data Quality Standard. The data quality standard is a maximum encounter data rejection rate for each file type in the ODM-specified format as follows:

837 Dental: 15%
837 Institutional: 15%
837 Professional: 15%
NCPDP: 15%

Information from ODM 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 MCPs that have had Medicaid membership for one year or less.

Measure. The rate of encounters that are submitted to ODM and accepted (i.e. accepted encounters per 1,000-member months).

Measurement Period. The measurement period for this measure is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment. This measure will not be calculated for SFY 2017.

Data Quality Standard. The data quality standard is a monthly minimum accepted rate of encounters for each file type in the ODM-specified medium per format as follows:

- Third through sixth month with membership: Not Applicable for SFY 2017.
- Seventh through twelfth month of membership: Not Applicable for SFY 2017.

b. **Encounter Data Accuracy Studies.** The MCP shall ensure collection and submission of accurate data to ODM. Failure to do so jeopardizes the MCPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

i. **Measure 1** *(This measure is calculated for MAGI and Adult Extension members only).* The focus of this accuracy study will be on delivery encounters. Its primary purpose will be to verify that the MCP submits encounter data accurately and to ensure only one payment is made per delivery. The rate of appropriate payments will be determined by comparing a sample of delivery payments to the medical record.

Measurement Period. In order to provide timely feedback on the accuracy rate of encounters, the measurement period will be the most recent from when the measure is initiated. This measure is conducted annually.

Medical records retrieval from the provider and submittal to ODM or its designee is an integral component of the validation process. ODM has optimized the sampling to minimize the number of records required. This methodology requires a high record submittal rate. To aid the MCP in achieving a high submittal rate, ODM will give at least an 8-week period to retrieve and submit medical records as a part of the validation process. A record submittal rate will be calculated as a percentage of all records requested for the study.

Data Quality Standard 1 for Measure 1. For results that are finalized during the contract year, the accuracy rate for encounters generating delivery payments is 100%.

Data Quality Standard 2 for Measure 1. A minimum record submittal rate of 85%.

ii. **Measure 2.** This accuracy study will compare the accuracy and completeness of payment data stored in the MCPs' claims systems during the study period to payment data submitted to and accepted by ODM. Two levels of analysis will be conducted: one to evaluate encounter data completeness for which two rates will be calculated and one to evaluate payment data accuracy. Encounter data completeness and payment accuracy will be determined by aggregating data across claim types i.e., dental, institutional (inpatient, outpatient, and other), professional, and pharmacy. Encounter data completeness for all claim types will be evaluated at the detail level. Payment data accuracy for each claim type will be evaluated based on how encounters are processed—i.e., either paid at the detail level or at the header level. As such, evaluation of payment data accuracy will be as follows: Dental and professional payment comparisons will be at the detail level; Inpatient-institutional payment comparisons will be at the header level, while outpatient-institutional and other-institutional payment comparisons will be at the detail level; and Pharmacy payment comparisons will be at the header level.

Encounter Data Completeness (Level 1).

- **Omission Encounter Rate.** The percentage of encounters in the MCP's fully adjudicated claims file not present in the ODM encounter data files.

- **Surplus Encounter Rate.** The percentage of encounters in the ODM encounter data files not present in the MCP's fully adjudicated claims files.

Payment Data Accuracy (Level 2). Payment Error Rate. The percentage of matched encounters between the ODM encounter data files and the MCP's fully adjudicated claims files where a payment amount discrepancy was identified.

Measurement Period. In order to provide timely feedback on the omission rate of encounters, the measurement period will be the most recent from when the study is initiated. This study is conducted annually.

Data Quality Standard for Measure 2 (For SFY 2018 and SFY 2019).

- **For Level 1.** An omission encounter rate and a surplus encounter rate of no more than 10% at the line-level records.

- **For Level 2.** A payment error rate of no more than 4% for each claim type based on how encounters are processed—i.e., either paid at the detail level or at the header level.

c. **Encounter Data Payments Compared to Managed Care Cost Report Information.** This measure is calculated separately for the ABD, CFC, and Adult Extension populations.

Measure. The difference between the MCP payment amounts as reported on the encounter data and on the Managed Care Cost Reports, as a percentage of the total cost reported on the Managed Care Cost Reports, by category of service, and rate cell.

Measurement Period. The measurement periods for the SFY 2018 and SFY 2019 are outlined in Table 10 below. This measure will be *informational only* for the duration of this Agreement.

Table 11. Measurement Periods for the SFY 2018 and SFY 2019 Contract Periods – Encounter Data Payments Compared to Managed Care Cost Report Information.

Quarterly Measurement Periods	Encounter Data File Update	Quarterly Report Estimated Issue Date
SFY 2018 Contract Period		
Qtr 1: 2018	June 2018	June 2018
Qtr 2: 2018	September 2018	September 2018
Qtr 3:2018	December 2018	December 2018
Qtr 4: 2018	March 2019	March 2019
SFY 2019 Contract Period		
Qtr 1:2019	June 2019	June 2019
Qtr 2: 2019	September 2019	September 2019
Qtr 3:2019	December 2019	December 2019
Qtr 4:2019	March 2020	March 2020

Qtr 1-January to March; Qtr 2= April to June; Qtr 3= July to September; Qtr4= October to December

d. **Encounter Data Submission.** Information concerning the proper submission of electronic data interchange (EDI) encounter transactions may be obtained from the Ohio Department of Medicaid (ODM) website. The website contains Encounter Data Companion Guides for the Managed Care 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 U277 Unsolicited Claim/Encounter Status Notifications, the 824 Application Advice, and the TA1 Transmission Acknowledgement are also available on the website. The Encounter Data Companion Guides shall be used in conjunction with the X12 Implementation Guides for EDI transactions.

Information concerning Managed Care encounter data measures may be obtained from the Ohio Department of Medicaid's Methodology for Covered Families & Children (CFC), Aged, Blind, or Disabled (ABD), and Adult Extension (Group VIII) 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 Encounter Data Minimum Number of Encounters required by each plan, the Encounter Data Submission Schedule, and the Encounter Data Certification Letter guidelines.

For specific encounter data submission guidelines related to Delivery Kick Payments (DKP), please refer to the Modified Adjusted Gross Income (MAGI) and MAGI Adult Extension Delivery Payment Reporting Procedures and Specifications for ODM Managed Care Plans document located on the ODM website.

i. **Encounter Data Submission Procedure.** The MCP shall submit encounter data files to ODM per the specified schedule and within the allotted amount established in the Ohio Department of Medicaid's Methodology for Covered Families & Children (CFC), Aged,

Blind, or Disabled (ABD), and Adult Extension (Group VIII) Encounter Data Quality Measures document.

The MCP 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 MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO.

ii. **Timeliness of Encounter Data Submission.** ODM requires MCP-paid encounters be submitted no later than 35 calendar days after the end of the month in which they were paid. MCPs shall report encounter data submission lag time on a monthly basis to ODM. Results may be subject to an audit by ODM and/or its designee.

Measure. The percentage of the MCP's total monthly paid encounters that are submitted to ODM and accepted within 35 calendar days of the month in which they were paid, (e.g., encounters paid by the MCP in January 2018 that are submitted to ODM and accepted on or before March 7th2018, divided by the total number of encounters paid by the MCP in January 2018).

Measurement Periods.

- **SFY 2019**. The monthly report received in May 2019 and June 2019.
- **SFY 2020**. The monthly report received in July 2019, August 2019, September 2019, October 2019, November 2019, December 2019, January 2020, February 2020, March 2020, and April 2020.

Data Quality Standard. The data quality standard is greater than or equal to 90%.

iii. **Required Monthly Minimum Number of Encounters Accepted Into MITS.**

Managed Care Plan	Required Number of Institutional and Professional	Required Number of Pharmacy NCPDP	Required Number of Dental
CareSource	750,000	1,000,000	32,000
UnitedHealthcare	275,000	320,000	15,000
Molina	222,000	312,000	14,000
Buckeye	160,000	240,000	10,000
Paramount	176,000	172,000	9,600

Measure. The percentage of the number of required monthly encounters accepted into MITS per the table above.

Measurement Periods.

- **SFY 2019**. April 2019, May 2019 and June 2019.
- **SFY 2020**. 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.

Data Quality Standard. The data quality standard is equal or greater than 100%.

2. **MCP Self-reported, Audited HEDIS Data.**

   a. **Annual Submission of HEDIS IDSS Data.** The MCP is required to collect, report, and submit to ODM self-reported, audited HEDIS data (see *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*) for the full set of HEDIS measures reported by the MCP to NCQA for Ohio Medicaid members. This shall include all HEDIS measures listed in Appendix M. The self-reported, audited HEDIS data are due to ODM no later than five business days after the NCQA due date.

   b. **Annual Submission of Final HEDIS Audit Report (FAR).** The MCP is required to submit to ODM their FAR that contains the audited results for the full set of HEDIS measures reported by the MCP to NCQA for Ohio Medicaid members. This shall include all HEDIS measures listed in Appendix M. The FAR is due to ODM no later than five business days after the NCQA due date (see *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*).

      Note: ODM will review the MCP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. ODM reserves the right to pursue corrective action based on this review (see Appendix N).

   c. **Data Certification Requirements for HEDIS IDSS Data and Final HEDIS Audit Report.** In accordance with 42 CFR 438.600, the MCP 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 MCP 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 Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*.

   d. **Annual Submission of Member Level Detail Records for Specified HEDIS Measures.** The MCP is required to submit member level detail records for specific HEDIS measures, in accordance with *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results.* The required member level detail will be used to meet CMS reporting requirements for the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set).

3. **Care Management Data.** ODM designed a Care Management System (CAMS) in order to monitor MCP compliance with program requirements specified in Appendix K. The MCP's care management data submission will be assessed for completeness and accuracy. The MCP is responsible for submitting a care management file per ODM's specifications. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with care management requirements. The MCP shall also submit a letter of certification, using the form required by ODM, with each CAMS data submission file. The specifications for submitting the care management file and instructions for submitting the data certification letter are provided in *the ODM Care Management Excel File and Submission Specifications*.

4. **Timely Submission of Care Management Files.** The MCP shall submit Care Management files on a monthly basis according to the specifications established in the *ODM Care Management Excel File and Submission Specifications.*

5. **Appeals and Grievances Data.** Pursuant to OAC rule 5160-26-08.4, the MCP 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 *ODM Appeal File and Submission Specifications* and *ODM* 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 MCP 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. **Utilization Management Data.** Pursuant to OAC rule 5160-26-03.1, the MCP 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 *ODM Utilization Management Tracking Database: Prior Authorization File and Submission Specifications* document.

   An MCP 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.

7. **CAHPS Data.**

   a. **Annual CAHPS Survey Administration and Data Submission.** The MCP is required to contract with an NCQA Certified HEDIS Survey Vendor to administer an annual CAHPS survey to the MCP's Ohio Medicaid members, per the survey administration requirements outlined in the *ODM CAHPS Survey Administration and Data Submission Specifications*. The survey data shall be submitted to NCQA, The CAHPS Database, and ODM's designee per the data submission requirements and by the due dates established in the *ODM CAHPS Survey Administration and Data Submission Specifications*.

b. **CAHPS Data Certification Requirements.** The MCP is required to annually submit to ODM three CAHPS data certification letters, one that attests to the MCP's adherence to ODM's requirements for the CAHPS survey administration and data submission to NCQA, a second that attests to the MCP's adherence to ODM's requirements for the CAHPS data submission to The CAHPS Database, and a third that attests to the MCP's adherence to ODM's requirements for the CAHPS data submission to ODM's designee. . The MCP's CAHPS data certification letters shall be submitted per the instructions and by the due dates provided in the *ODM CAHPS Survey Administration and Data Submission Specifications.*

8. **Third Party Liability (TPL) Data Submissions.** The MCP shall provide ODM with a TPL data file that includes all TPL change information for members. This data file is due to ODM each week by no later than 11:00pm Thursday night. Beginning January 1, 2020, the MCP shall reconcile the ODM weekly TPL change file with their data and provide ODM with a data file that contains any discrepancies, additions, and deletions. The MCP shall submit this information electronically to ODM pursuant to the *ODM Third Party Liability File and Submission Specifications*. MCP must follow the guidelines specified in the Third Party Liability (TPL) Change Only File – FAQs for MCOs available online at https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans#1910242-frequently-asked-questions.

9. **Primary Care Provider (PCP) Data.** ODM requires assignment of primary care providers (PCPs) to members as specified in OAC rule 5160-26-03.1.

   a. The MCP is responsible for submitting a PCP data file every quarter. The MCP's PCP data file submission will be assessed for completeness and accuracy. The MCP shall also submit a letter of certification, using the form required by ODM, with each PCP data file submission. The specifications for submitting the PCP data file and instructions for submitting the data certification letter are provided in *the ODM Primary Care Provider Data File and Submission Specifications*.

   b. **Timely Submission of PCP Data Files.** The MCP shall submit a PCP data file, and corresponding certification letter, on a quarterly basis according to the specifications established in the *ODM Primary Care Provider Data File and Submission Specifications.*

10. **Medicaid Managed Care Quarterly Enrollment Files.** Accurate MCP enrollment records are a critical component of determining accurate rates for measures where recipient enrollment is used as the basis for calculating rates. In order to ensure the most accurate and complete enrollment records possible for the MCP, ODM is creating Quarterly Enrollment files to be sent to the MCP for the purpose of enrollment verification Details regarding specifications for these enrollment files can be found in *ODM's Medicaid Managed Care Plan Quarterly Enrollment Data File Specifications.*

    The MCP may voluntary 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 *Medicaid Managed Care Plan Addition and Deletion Enrollment Data File Specifications*.

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

11. **Submission of Provider Preventable Conditions Data**. Pursuant to 42 CFR 438.3(g), the MCP shall identify the occurrence of all provider preventable conditions (PPCs). The MCP shall report identified PPCs, regardless of the provider's intention to bill for that event, to ODM in a manner specified by ODM.

12. **Submission of and Response to Coordinated Services Program (CSP) Data**. The MCP shall submit its enrollment of members in the CSP program via the 'Inbound from MCP' file no later than the 15th calendar day of each month to ensure CSP enrollment is recorded in the 834 files. MCPs shall monitor the 'Outbound to MCP' file to review file submission errors and correct submissions via the 'Inbound from MCP' file, including changes in enrollment, new enrollments, and disenrollments.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX M

QUALITY MEASURES AND STANDARDS

The Ohio Department of Medicaid (ODM) has established Quality Measures and Standards to evaluate MCP performance in key program areas (i.e., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and/or focus areas of the ODM Quality Strategy. Most measures have one or more Minimum Performance Standards. Specific measures and standards are used to determine MCP performance incentives. Measures with a minimum performance standard are used to determine MCP noncompliance sanctions. A limited number of measures are informational/reporting only and have no associated standards, incentives, or sanctions. All of the measures utilized for performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ), widely used for evaluation of Medicaid and/or managed care industry data. Performance measures and standards are subject to change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as deemed relevant.

The establishment of Quality Measures and Standards in this appendix is not intended to limit the assessment of other indicators of performance for quality improvement activities. Performance on multiple measures will be assessed and reported to the MCPs and others, including Medicaid consumers.

1. **Quality Measures.** For SFY 2019, SFY 2020 and SFY 2021, specific measures are designated for use in the Quality Based Assignment and Quality Withhold Incentive Systems (see Appendix O). For these measures, results will be used in determining the award of incentives for participating MCPs. For the measures that include a Minimum Performance Standard, failure to meet a standard will result in the assessment of a noncompliance penalty (see Appendix N).

   The MCP is evaluated on each measure using statewide results that include all regions in which the MCP has membership. Performance results will be used to assess the quality of care provided by the MCP to the managed care population and may be used for federal reporting and ODM public reporting purposes (e.g., MCP report cards). Results for each measure are calculated per MCP and include all of the MCP's Ohio Medicaid members who meet the criteria specified by the methodology for the given measure. MCP performance is assessed using ODM calculated performance measurement data for the CHIPRA, AHRQ, and AMA/PCPI measures; NCQA calculated summary rates for the HEDIS/CAHPS survey measures; and MCP self-reported, audited HEDIS data for the NCQA HEDIS measures listed in Table 1 below. The ODM methodology for the CHIPRA, AHRQ, and AMA/PCPI measures in Table 1 is posted, upon publication, to the *Medicaid Managed Care Program* page of the ODM website. The HEDIS measures and HEDIS/CAHPS survey measures in Table 1 are calculated in accordance with *NCQA's Volume 2: Technical Specifications* and *NCQA's Volume 3: Specifications for Survey Measures*, respectively. The previous calendar year is the standard measurement year for HEDIS data.

   Measures, Measurement Sets, Standards, and Measurement Years. The measures, accompanying Minimum Performance Standards, and measurement years for the SFY 2019, SFY 2020, and SFY 2021 contract periods are listed in Table 1 below. The measurement set associated with each measure is also provided. The measures used in the Pay for Performance (P4P) Incentive System are denoted with an asterisk (*) in the respective Minimum Performance Standard columns and the standard is bolded. The measures used in the Quality Based Assignment and Quality Withhold Incentive Systems each year are denoted with a QBA or QW in the respective Minimum Performance Standard columns. No standard will be established or compliance assessed for measures designated 'reporting only' for the corresponding

year. Minimum performance standards will be established for the subsequent SFY for Reporting Only measures denoted with a double asterisk (Reporting Only **).

Table 1. SFY 2019, SFY 2020 and SFY 2021 Performance Measures, Measurements Sets, Standards, and Measurement Years.

Measure	Measurement Set	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year	SFY 2020 Minimum Perf. Std.	SFY 2020 Measurement Year	SFY 2021Minimum Perf. Std.	SFY 2021 Measurement Year
Quality Strategy Population Stream: **Healthy Children**							
Well-Child Visits in the First 15 Months of Life – Six or More Well-Child Visits	NCQA/HEDIS	**QW**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA/HEDIS	**QW**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Adolescent Well-Care Visits	NCQA/HEDIS	**QW**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation	NCQA/HEDIS	≥ 40.24%	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months, 25 Months - 6 Years, 7-11 Years, and 12-19 Years	NCQA/HEDIS	12-24 mos. ≥ 93.27%	CY 2018	12-24 Mos. ≥ 93.64%	CY 2019	12-24 Mos. ≥ MPSO	CY 2020
		25 Mos. - 6 Yrs. ≥ 84.94%		25 Mos. - 6 Yrs. ≥ 84.39%		25 Mos. - 6 Yrs. MPSO	
		7-11 Yrs. ≥ 87.58%		7-11 Yrs. ≥ 87.73%		7-11 Yrs. MPSO	
		12-19 Yrs. ≥ 85.65%		12-19 Yrs. ≥ 85.81%		12-19 Yrs. MPSO	
Appropriate Testing for Children With Pharyngitis	NCQA/HEDIS	Reporting Only**	CY 2018	Reporting Only	CY 2019	Reporting Only	CY 2020
General Child Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS/CAHPS	≥ 2.51	CY 2018 (Survey conducted in CY 2019)	Reporting Only	CY 2019 (Survey conducted in CY 2020)	MPSO	CY 2020 (Survey conducted in CY 2021)
General Child - Customer Service Composite (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	≥ 2.50	CY 2018 (Survey conducted in CY 2019)	Reporting Only	CY 2019 (Survey conducted in CY 2020)	MPSO	CY 2020 (Survey conducted in CY 2021)

Annual Dental Visits, Total Rate	NCQA/HEDIS	Reporting Only	CY 2018	≥ 36.14%	CY 2019	MPSO	CY 2020
Childhood Immunization Status (Combo 2)	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	Reporting Only	CY 2020
Childhood Immunization Status (Combo 3)	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	MPSO	CY 2020
Childhood Immunization Status (Combo 10)	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	Reporting Only	CY 2020
Immunizations for Adolescents (Combo 1)	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	Reporting Only	CY 2020
Immunization for Adolescents (HPV)	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	Reporting Only	CY 2020
Immunizations for Adolescents (Combo 2)	NCQA/HEDIS	Not Applicable	CY 2018	Not Applicable	CY 2019	MPSO	CY 2020
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition, Counseling for Physical Activity	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	Reporting Only	CY 2020
Lead Screening in Children	NCQA/HEDIS	Not Applicable	CY 2018	Not Applicable	CY 2019	MPSO	CY 2020
Quality Strategy Population Stream: **Women's Health**							
Prenatal and Postpartum Care - Timeliness of Prenatal Care	NCQA/HEDIS	**QBA** ≥ 64.48%	CY 2018	**QBA** Reporting Only	CY 2019	**QBA** Reporting Only	CY 2020
Prenatal and Postpartum Care - Postpartum Care	NCQA/HEDIS	**QBA** ≥ 45.76%	CY 2018	**QBA** Reporting Only	CY 2019	**QBA** Reporting Only	CY 2020
Percent of Live Births Weighing Less Than 2,500 Grams	CHIPRA	**QBA** ≤ 9.2%	CY 2018	**QBA** ≤ 9.2%	CY 2019	**QBA** **MPSO**	CY 2020
Breast Cancer Screening	NCQA/HEDIS	**QBA** ≥ 43.68%	CY 2018	**QBA** ≥ 48.31%	CY 2019	**QBA** **MPSO**	CY 2020
Cervical Cancer Screening	NCQA/HEDIS	**QBA** ≥ 38.36%	CY 2018	**QBA** ≥ 44.41%	CY 2019	**QBA** MPSO	CY 2020
Chlamydia Screening in Women, Total	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only**	CY 2019	MPSO	CY 2020
Quality Strategy Population Stream: **Behavioral Health**							
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS	Initiation Total **QW** Engagement Total Reporting Only**	CY 2018	Initiation Total **QW** Engagement Total ≥ 6.05%	CY 2019	Initiation Total **MPSO** Engagement Ages 13-17 **MPSO** Engagement Ages 18+ Reporting Only **	CY 2020
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	7-Day Follow-up, Total **QW**	CY 2018	7-Day Follow-up, Total **QW**	CY 2019	7-Day Follow-up, Ages 6-17 **QW**	CY 2020

						7-Day Follow-up, Ages 18-64 **QW**	
		30-Day Follow-up, Total Reporting Only **		30-Day Follow-up, Total ≥ 40.00%		30-Day Follow-up, Total MPSO	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total	NCQA/HEDIS	≥ 53.81%	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Use of Multiple Concurrent Antipsychotics in Children and Adolescents, Total	NCQA/HEDIS	**QW**	CY 2018	Measure Retired Eff. SFY 2020	CY 2019	Measure Retired Eff. SFY 2020	CY 2020
Antidepressant Medication Management – Effective Acute Phase Treatment, Effective Continuation Phase Treatment	NCQA/HEDIS	Acute Phase ≥ 42.17%	CY 2018	Acute Phase ≥ 45.34%	CY 2019	Acute Phase MPSO	CY 2020
		Continuation Phase Reporting Only**		Continuation Phase ≥ 29.85%		Continuation Phase MPSO	
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	NCQA/HEDIS	Reporting Only	CY 2018	≥ 45.00%	CY 2019	MPSO	CY 2020
Follow-Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	NCQA/HEDIS	Reporting Only	CY 2018	≥ 57.09%	CY 2019	MPSO	CY 2020
Mental Health Utilization, all rates (except Inpatient)	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	Reporting Only	CY 2020
Mental Health Utilization - Inpatient	NCQA/HEDIS	Reporting Only	CY 2018	≤ 1.13	CY 2019	**MPSO**	CY 2019
Follow-Up After Emergency Department Visit for Mental Illness	NCQA/HEDIS	7-Day Follow-up Reporting Only	CY 2018	7-Day Follow-up ≥ 37.04%	CY 2019	7-Day Follow-up MPSO	CY 2020
		30-Day Follow-up Reporting Only		30-Day Follow-up ≥ 52.59%		30-Day Follow-up MPSO	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence, Total	NCQA/HEDIS	7-Day Follow-up Reporting Only	CY 2018	7-Day Follow-up ≥ 10.36%	CY 2019	7-Day Follow-up MPSO	CY 2020
		30-Day Follow-up Reporting Only		30-Day Follow-up ≥ 16.01%		30-Day Follow-up MPSO	
Use of Opioids at High Dosage	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only**	CY 2019	Reporting Only**	CY 2020
Use of Opioids From Multiple Providers- Multiple Providers, Multiple Pharmacies, Multiple Prescribers and Multiple Pharmacies	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only**	CY 2019	Multiple Prescribers MPSO	CY 2020
						Multiple Pharmacies MPSO	
						Multiple Prescribers & Multiple Pharmacies MPSO	

Risk of Continued Opioid Use	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	Reporting Only	CY 2020
Quality Strategy Population Stream: **Chronic Conditions**							
Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)	NCQA/HEDIS	**QW**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Comprehensive Diabetes Care – HbA1c Testing	NCQA/HEDIS	**QW**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	NCQA/HEDIS	**QW**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	NCQA/HEDIS	**QW**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Comprehensive Diabetes Care – HbA1c Control (<8.0%)	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	MPSO	CY 2020
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA/HEDIS	Reporting Only	CY 2018	Reporting Only	CY 2019	MPSO	CY 2020
Statin Therapy for Patients With Diabetes, Received Statin Therapy	NCQA/HEDIS	≥ 57.73%	CY 2018	Reporting Only	CY 2019	MPSO	CY 2020
PQI 16: Lower-Extremity Amputation, Patients w/ Diabetes	AHRQ	≤ 2.4	CY 2018	Eliminated effective SFY2020	Eliminated Effective SFY 2020	Eliminated effective SFY2020	Eliminated effective SFY2020
Controlling High Blood Pressure	NCQA/HEDIS	**QW**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Statin Therapy for Patients With Cardiovascular Disease, Received Statin Therapy, Total	NCQA/HEDIS	**QW**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Adult BMI Assessment	NCQA/HEDIS	**≥28.79%**	CY 2018	**QW**	CY 2019	**MPSO**	CY 2020
Annual Monitoring for Patients on Persistent Medication, Total	NCQA/HEDIS	Reporting Only	CY 2018	Measure Retired Eff. SFY 2020	CY 2019	Measure Retired Eff. SFY 2020	CY 2020
Medication Management for People With Asthma – Medication Compliance 50%, Total Rate; Medication Compliance 75 %, Total Rate	NCQA/HEDIS	50% Total Rate Not Applicable 75% Total Rate ≥ 19.97%	CY 2018	50% Total Rate Reporting Only 75% Total Rate ≥ 24.47%	CY 2019	50% Total Rate Reporting Only 75% Total Rate MPSO	CY 2020
Pharmacotherapy Management of COPD Exacerbation	NCQA/HEDIS	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only** Dispensed a Systemic Bronchodilator within 30 calendar days: Reporting Only	CY 2018	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only Dispensed a Systemic Bronchodilator within 30 calendar days: Reporting Only	CY 2019	Dispensed Systemic Corticosteroid Within 14 calendar days: Reporting Only Dispensed a Systemic Bronchodi-lator within 30 calendar days: Reporting Only	CY 2020
Quality Strategy Population Stream: **Healthy Adults**							
Adults' Access to Preventive/Ambulatory Health Services – Total	NCQA/HEDIS	≥76.17%	CY 2018	≥75.84%	CY 2019	MPSO	CY 2020
Tobacco Use: Screening and Cessation	AMA-PCPI	Reporting Only**	CY 2018	≥ 10%	CY 2019	MPSO	CY 2020
Adult Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS/CAHPS	≥ 2.35	CY 2018 (Survey conducted in CY 2019	Reporting Only	CY 2019 (Survey	MPSO	CY 2020 (Survey

					conducted in CY 2020		conducted in CY 2021
Adult - Customer Service Composite (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	≥ 2.48	CY 2018 (Survey conducted in CY 2019)	Reporting Only	CY 2019 (Survey conducted in CY 2020	MPSO	CY 2020 (Survey conducted in CY 2021
Ambulatory Care-Emergency Department (ED) Visits	NCQA/HEDIS	Reporting Only	CY 2018	≤ 82.21	CY 2019	MPSO	CY 2020
Inpatient Utilization – General Hospital/Acute Care	NCQA/HEDIS	Not Applicable	Not Applicable	Reporting Only	CY 2019	Reporting Only	CY 2020

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

** = Minimum Performance Standard will be established for the subsequent state fiscal year
TBD= Minimum Performance Standard: to be determined
QBA = Quality-Based Auto-Assignment measure
QW = Quality Withhold measure
MPSO = Minimum Performance Standard will be based on outliers identified when all MCPs' results are compared

2. **Additional Operational Considerations.**

   a. **Measures and Measurement Years.** ODM reserves the right to revise the measures and measurement years established in this appendix (and any corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's performance level for that contract period.

   b. **Performance Standards – Compliance Determination.** In the event the MCP's performance cannot be evaluated for a performance measure and measurement year established in Table 1. of this appendix, ODM in its sole discretion will deem the MCP to have met or to have not met the standard(s) for that particular measure and measurement year depending on the circumstances involved (e.g., if a HEDIS measure was assigned an audit result of "Not Report" on the MCP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCP, ODM would deem the MCP to have not met the standard(s) for that measure and measurement year).

   c. **Performance Standards – Retrospective Adjustment.** ODM will implement the use of a uniform methodology, as needed, for the retrospective adjustment of any Minimum Performance Standard listed in Table 1 of this appendix, except for the CAHPS measure standards. This methodology will be implemented at ODM's sole discretion.

For a comprehensive description of the standard adjustment methodology, see *ODM Methods for the Retrospective Adjustment of Quality and P4P Measure Standards.*

The sanctions for noncompliance 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 MCP if the MCP is found to have violated this Agreement, or any other applicable law, rule, or regulation. It does not in any way limit ODM from requiring Corrective Action Plans (CAPs) and program improvements, or from imposing any of the sanctions specified in 42 CFR 438.706 and OAC rule 5160-26-10 or any other additional compliance actions, including the proposed termination, amendment, or nonrenewal of this Agreement. Any actions undertaken by ODM under this appendix are not exclusive to any other compliance action it may impose or available to ODM under applicable law or regulations. Pursuant to 42 CFR 438.704, any civil monetary penalties imposed by ODM shall not exceed mandated maximum figures.

    b. As set forth in OAC rule 5160-26-10, regardless of whether ODM imposes a sanction, the MCP is required to initiate corrective action for any MCP program violation or deficiency as soon as the violation or deficiency is identified by the MCP or ODM. The MCP is required to report to ODM when it becomes aware of any violation that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the MCP to deliver covered services, or affect the member's ability to access covered services.

    c. If ODM determines the MCP has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act not specifically identified within this Agreement, ODM may (1) require the MCP to permit any of its members to disenroll from the MCP without cause, or (2) suspend any further new member enrollments to the MCP, or both.

    d. Program violations that reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODM first becomes aware of this noncompliance.

    e. ODM retains the right to use its discretion to determine and apply the most appropriate compliance action based on the severity of the noncompliance, a pattern of repeated noncompliance, and number of beneficiaries affected. In instances where the MCP is able to document, to the satisfaction of ODM, that the violation and precipitating circumstances were beyond its control and could not have reasonably been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.), ODM may, in its discretion, utilize alternative methods (i.e., a remediation plan) in lieu of the imposition of sanctions/remedial actions as defined in this appendix.

    A Remediation Plan is a structured activity or process implemented by the MCP 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 this appendix.

f. ODM will issue all notices of noncompliance in writing to the identified MCP contact.

2. **Types of Sanctions/Remedial Actions.** ODM may impose sanctions/remedial actions, including, but not limited to, the items listed below.

   a. **Corrective Action Plans (CAPs).** A CAP is a structured activity, process or quality improvement initiative implemented by the MCP to improve identified operational and clinical quality deficiencies. All CAPs shall be submitted in the manner specified by ODM.

      The MCP 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 MCP to ensure its compliance with a program requirement will remain in effect until the MCP 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 MCP or if the MCP has failed to submit a CAP, ODM may require the MCP to comply with an ODM-developed or "directed" CAP.

      Where a sanction is assessed for a violation in which the MCP has previously been assessed a CAP the MCP may be assessed escalating sanctions under this Agreement.

   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 MCP is able to document that the precipitating circumstances were completely beyond its control and could not have been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.).

         In cases where an MCP-contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), ODM may assess points unless to the satisfaction of ODM: (1) the MCP can document that it provided sufficient notification or education to providers of applicable program requirements and prohibited activities; and (2) the MCP took immediate and appropriate action to correct the problem and to ensure it will not reoccur. ODM will review repeated incidents and determine whether the MCP has a systemic problem. If ODM determines that a systemic problem exists, further sanctions or remedial actions may be assessed against the MCP.

1. **5 Points.** ODM may, in its discretion, assess five (5) points for any instance of noncompliance with applicable rules, regulations, or contractual requirements. Instances of noncompliance can include, but are not limited to, those that (1) impair a member's or potential enrollee's ability to obtain accurate information regarding MCP services, (2) violate a care management process, (3) impair a member's or potential enrollee's ability to obtain correct information regarding services or (4) infringe on the rights of a member or potential enrollee. Examples of five (5) point violations include, but are not limited to the following:

    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 MCP 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 MCP'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 twelve (12) months.

    k. Failure to actively participate in quality improvement projects or performance improvement projects facilitated by ODM and/or the EQRO.

    l. Failure to meet provider network performance standards.

    m. A violation of a care management process specified in Appendix K of the

Agreement that does not meet the standards for a 10-point violation. Examples include but are not limited to the following:

i. Failure to 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. Failure to adequately assess an individual's needs including the evaluation of mandatory assessment domains;

iii. Failure to update an assessment upon a change in health status, needs or significant health care event;

iv. Failure to develop or update a care plan that appropriately addresses assessed needs of a member;

v. Failure to monitor the care plan;

vi. Failure to complete a care gap analysis that identifies gaps between recommended care and care received by a member;

vii. Failure to update the care plan in a timely manner when gaps in care or change in need are identified;

viii. Failure to coordinate care for a member across providers, specialists, and team members, as appropriate;

ix. Failure to adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls; or

x. Failure to make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; conduct timely follow up with the member and provider, as appropriate; or arrange for services specified in the discharge/transition plan.

n. Failure to notify providers of claim reprocessing and/or payment recovery within the timeframe specified in this Agreement.

2. **10 Points.** ODM may in its discretion assess ten (10) 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 MCP to deliver, or a member to access, covered services; (2) place a member at risk for a negative health outcome; or (3) jeopardize the safety and welfare of a member.

Examples include, but are not limited to, the following:

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).

b. Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member.

c. Failure to provide medically-necessary Medicaid covered services to members.

d. Failure to participate in transition of care activities or discharge planning activities.

e. Failure to process prior authorization requests within the prescribed time frames.

f. Repeated failure to comply with an open remediation plan or CAP or a CAP closed in the last twelve (12) months.

g. The imposition of premiums or charges on members in excess of the premiums or charges permitted under the Medicaid program.

h. Misrepresentation or falsification of information that the MCP furnishes to ODM.

i. Misrepresentation or falsification of information that the MCP furnishes to a member, potential member, or health care provider.

j. Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210.

k. Violation of a care management process as specified in Appendix K.

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 Agreement Termination

ii. **Specific Pre-Determined Sanctions**

1. **Adequate Network-Minimum Provider Panel Requirements.** Any deficiencies in the MCP's provider network specified in Appendix H of this Agreement or by ODM, may at ODM's discretion, result in the assessment of a $1,000 nonrefundable financial sanction for each category (practitioners, PCP capacity, hospitals), for each county. Compliance will be assessed at least quarterly.

   ODM may assess additional sanctions (e.g., CAPs, points, financial sanctions) if the MCP violates any other provider panel requirements or the MCP's member has experienced problems accessing necessary services due to lack of an adequate provider panel.

2. **Adequate Provider Panel Time and Distance Requirements.** The MCP shall submit to ODM electronic time and distance reports as per Appendix H for each county on a quarterly basis and according to ODM's specifications. This will include all required time and distance reports needed to calculate each measure under this requirement. Reports will be due to ODM on the first Monday of January, April, July, and October. The MCP shall ensure that 90% of beneficiaries in each county have access to at least one provider or facility for each type within the published county at all times. The MCP will be non-compliant if they have been provider panel deficient for two consecutive quarters for any time and distance per provider type. If the MCP has a provider panel deficiency for two consecutive quarters, ODM will assess a financial penalty of $1,000.00 per provider type that does not meet the time and distance requirements. For instance, when an MCP is out of compliance for time and distance for an allergist in seven counties, ODM will assess a total of $7,000.00 in penalties for that provider type. ODM may assess additional sanctions (e.g., CAPs, points, financial sanctions) if the MCP violates any other time and distance requirements or the MCP's member was unable to access the necessary services due to the MCP's failure to assure that time and distance requirements are met. Any monetary damages that otherwise would be assessed pursuant to this appendix may be reduced, at ODM's discretion, if the MCP reports the failure or noncompliance to ODM prior to notice of noncompliance. The amount of the reduction shall be no more than ninety percent of the total value of the monetary damages.

3. **Network Performance Baseline Measure.** ODM may assess a $50,000 nonrefundable financial sanction for each baseline measure not met on the bi-annual Network Performance surveys.

   The sanction may be waived by ODM if the MCP submits sufficient documentation to demonstrate 92% of the PCP providers in the sample are participating within 30 days of the compliance notification. ODM will supply the sanctioned MCP with a list of PCP providers from the sampled survey who stated they are not in contract with the MCP, for reference.

4. **Late Submissions.** All submissions, data, and documentation submitted by the MCP shall be received by ODM within the specified deadline and shall represent the MCP in an honest and forthright manner. If the MCP is unable to meet a program deadline or data/documentation submission deadline, the MCP 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 MCP to meet a deadline stipulated by ODM. All such requests will be evaluated upon this standard.

   If the MCP fails to provide ODM with any required submission, data, or documentation, ODM may assess a nonrefundable financial sanction of $100 per calendar day, unless the MCP requests and is granted an extension by ODM. Assessments for late submissions will be done monthly.

5. **Noncompliance with Claims Adjudication Requirements.** If ODM finds the MCP is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, ODM may assess the MCP with a financial sanction of $20,000 per calendar day for the period of noncompliance. Additionally, the MCP may be assessed 5 points per incident of noncompliance.

   If ODM has identified specific instances where the MCP has failed to take the necessary steps to comply with the requirements specified in Appendix C of the Agreement by (1) failing to notify non-contracting providers of procedures for claims submissions when requested or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the MCP may be assessed 5 points per incident of noncompliance.

6. **Noncompliance with Financial Performance Measures or the Submission of Financial Statements.** If the MCP fails to meet any standard for section 2 of Appendix J, ODM may require the MCP to complete a CAP and specify the date by which compliance shall be demonstrated. Failure by the MCP to meet the standard or otherwise comply with the CAP by the specified date may result in a new enrollment freeze unless ODM determines that the deficiency does not potentially jeopardize access to or quality of care or affect the MCP's ability to

meet administrative requirements (e.g., prompt pay requirements). Justifiable reasons for noncompliance may include one-time events (e.g., MCP investment in information system products).

If Financial Statements are not submitted to the Ohio Department of Insurance (ODI) by the due date, the MCP continues to be obligated to submit the report to ODM by ODI's originally specified due date unless the MCP requests and is granted an extension by ODM.

If the MCP fails to submit complete quarterly and annual Financial Statements on a timely basis, ODM will deem this a failure to meet the standards and may impose the noncompliance sanctions listed above for the indicators in Appendix J, Section 2, including a new enrollment freeze. The new enrollment freeze will take effect on the first of the month following the month ODM has determined that the MCP was non-compliant for failing to submit financial reports timely.

7. **Noncompliance with Medical Loss Ratio (MLR) Requirements.** The MCP is required to submit a consolidated MLR report for their Medicaid population for each MLR reporting year, specifically as defined in 42 CFR 438.8(e), 42 CFR 438.8(f), 42 CFR 438.8(h), and 42 CFR 438.8(g). The MCP shall comply with the directives as outlined in the remainder of 42 CFR 438.8 and any ODM directives required to satisfy the MLR requirements outlined in 42 CFR 438.74. The MCP is required to use the reporting tool provided by ODM to report the MLR reporting requirements for each contract year.

   The MLR calculation shall be aligned with federal standards during the term of this contract; however, ODM reserves the right to incorporate additional state-specific criteria and/or adjustments in the calculation of the MLR.

   The minimum MLR is 86%. Ninety (90) days after ODM's review of the MLR, the MCP will be required to remit back to the State a rebate in the amount equal to the difference between the calculated MLR and the target MLR of 86% multiplied by the revenue paid to the MCP during the contract year.

   The rebates paid to ODM will be calculated in aggregate across all eligibility groups in the Medicaid Managed Care program.

8. **Noncompliance with Reinsurance Requirements.** If ODM determines that (1) the MCP has failed to maintain reinsurance coverage as specified in Appendix J, (2) the MCP's deductible exceeds $100,000 without approval from ODM, or (3) the MCP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODM, then ODM may require the MCP 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 MCP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCP actually paid while it was out of compliance or (2) $50,000.

If ODM determines the MCP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, ODM may subject the MCP to a CAP.

9. **Noncompliance with Prompt Payment.** ODM may impose progressive sanctions on the MCP for not complying with the prompt pay requirements as specified in Appendix J of this Agreement.

    a. For the first instance of noncompliance during a rolling 12-month period for each claim type listed in Appendix J, ODM may assess a refundable financial sanction equal to .04% of the amount calculated in accordance with this appendix on each claim type and timeframe separately. The refundable financial sanction amount will be returned to the MCP if ODM determines the MCP is in full compliance with the prompt pay standards within the five consecutive reporting periods following the report period for which the refundable financial sanction was issued.

    b. For the second instance of noncompliance during a rolling 12-month period for each claim type listed in Appendix J, ODM may assess a nonrefundable financial sanction equal to .08% of the amount calculated in accordance with this appendix on each claim type and timeframe separately.

    c. Subsequent violations during a rolling 12-month period may result in an enrollment freeze of not less than three (3) months duration or until the MCP has come back into compliance.

10. **Noncompliance with claims payment systemic errors (CPSEs).** If the MCP fails to comply with the CPSE requirements as specified by ODM, then ODM may impose a nonrefundable financial sanction in the amount of $5,000 for each documented violation. Additionally, the MCP shall take all appropriate action to correct each violation documented by ODM.

11. **Noncompliance with Clinical Laboratory Improvement Amendments (CLIA).** If the MCP 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.

12. **Noncompliance with Abortion and Sterilization Hysterectomy Requirements.** If the MCP 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 MCP shall take all appropriate action to correct each violation documented by ODM.

13. **Refusal to Comply with Program Requirements**. If ODM has instructed the MCP that it shall comply with a specific program requirement and the MCP refuses, such refusal constitutes documentation that the MCP is no longer operating in

the best interests of the MCP's members or the state of Ohio, and ODM may move to terminate or non-renew this Agreement.

14. **Data Quality Submission Requirements and Measures (as specified in Appendix L).** ODM reserves the right to withhold an assessment of noncompliance under this appendix due to unforeseeable circumstances.

    a. **Data Quality Submission Requirements.**

        i. **Annual Submission of MCP Self-Reported, Audited HEDIS Data**. Performance is monitored annually. If the MCP fails to submit its self-reported, audited HEDIS data to ODM as specified in Appendix L, the MCP will be considered non-compliant with the standards for the self-reported, audited HEDIS performance measures in Appendix M for the corresponding contract period per this appendix. In addition, ODM may impose a non-refundable $300,000 financial sanction if the MCP's HEDIS data submission does not contain any measure(s) designated as 'reporting only' and/or 'informational only' in Appendix M for the corresponding contact period. Furthermore, the MCP may be disqualified from participation in the P4P incentive system in Appendix O for the corresponding contract period.

        ii. **Annual Submission of Final HEDIS Audit Report (FAR).** Performance is monitored annually. If the MCP fails to submit it's FAR to ODM as specified in Appendix L, the MCP will be considered non-compliant with the standards for the self-reported, audited HEDIS performance measures in Appendix M for the corresponding contract period per this appendix. In addition, the MCP may be disqualified from participation in the P4P incentive system in Appendix O for the corresponding contract period.

        ODM will review the MCP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. The MCP may be required to submit to ODM requested documentation to account for an NR audit designation. Based on its review of the MCP's FAR and any NR audit designations assigned, ODM reserves the right to pursue corrective action (such as requiring the MCP to implement a corrective action plan to resolve data collection and/or reporting issues).

        iii. **Data Certification Requirements for HEDIS IDSS Data and HEDIS Audit Report.** Performance is monitored annually. If the MCP fails to submit a required data certification letter to ODM

within the required time frame, ODM may impose a nonrefundable financial sanction of $100 per calendar day, unless the MCP requests and is granted an extension by ODM.

iv. **Annual Submission of Member Level Detail Records for Specified HEDIS Measures**. Performance is monitored annually. If the MCP fails to submit the required HEDIS measure member level detail records to ODM within the required time frame, ODM may impose a nonrefundable financial sanction of $100 per calendar day, unless the MCP requests and is granted an extension by ODM.

v. **Annual CAHPS Survey Administration and Data Submission.** Performance is monitored annually. If the MCP fails to administer a CAHPS survey and submit the survey data to NCQA, the CAHPS Database, and ODM's designee, as specified in Appendix L, ODM may impose a non-refundable $300,000 financial sanction. In addition, the MCP will be considered non-compliant with the standards for the CAHPS performance measure in Appendix M for the corresponding contract period, per this appendix.

vi. **CAHPS Data Certification Requirements.** Performance is monitored annually. If the MCP fails to submit a required CAHPS data certification letter to ODM within the required time frame, ODM may impose a nonrefundable financial sanction of $100 per calendar day, unless the MCP requests and is granted an extension by ODM.

b. **Data Quality Measures.** The MCP shall submit to ODM, by the specified deadline and according to ODM's specifications, all required data files and requested documentation needed to calculate each measure listed under this section. If the MCP fails to comply with this requirement for any measure listed under this section, then the MCP will be considered noncompliant with the standard(s) for that measure.

Unless otherwise specified, sanctions for noncompliance are assessed per MCP and measure for the MCP's overall Ohio Medicaid population (i.e., ABD, MAGI, and Adult Extension members).

i. **Encounter Data Volume.** Performance is monitored once every quarter for the entire measurement period for each of the following populations: ABD adults, ABD children, MAGI members, and Adult Extension members. Sanctions for noncompliance will be assessed separately, by population. For each population, if the standard is not met for every service category in all quarters of the measurement period, the MCP

will be determined to be noncompliant for the measurement period.

ODM will issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM will issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCP is determined to be noncompliant with the standard for this measure, ODM will issue a CAP. If the MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM will impose a financial sanction of two percent of the amount calculated in accordance with this appendix. (Financial sanctions will not be levied in subsequent, consecutive quarters the MCP is determined to be noncompliant.) If the MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM will impose a new member enrollment freeze. A financial sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

ii. **Rejected Encounters.** Performance is monitored once every quarter for Measure 1 and once every month for Measure 2. Compliance determination with the standard applies only to the measurement period under consideration and does not include performance in previous measurement periods. Files in the ODM-specified medium per format that are totally rejected will not be considered in the determination of noncompliance. If the standard is not met for every file type, the MCP may be determined to be noncompliant for the measurement period.

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 MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCP 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 MCP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Special consideration may be made for MCPs with less than 1,000 members.

A financial sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

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 MCP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are not consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time the MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCP 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 MCP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Special consideration may be made for MCPs with less than 1,000 members.

A financial sanction issued under this section will be returned to the MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

iv. **Encounter Data Accuracy Study - Payment Accuracy Measure.** The first time the MCP is determined to be noncompliant with the standard for either level 1 or level 2 for this measure, the MCP 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 MCP 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 MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued.

v. **Encounter Data Accuracy Study - Delivery Payment Measure**. Compliance with this measure will only be assessed for the MAGI population and Adult Extension members (combined). The MCP shall participate in a detailed review of delivery payments made for deliveries during the measurement period. The required accuracy rate for encounters generating delivery payments is 100%; therefore, any duplicate delivery payments or delivery payments not validated shall be returned to ODM. For all encounter data accuracy studies completed during the contract period, if the MCP does not meet the minimum record submittal rate of 85%, ODM may impose a non-refundable $10,000 financial sanction. However, no financial sanctions will be imposed if the MCP is in its first contract year of Medicaid program participation.

vi. **Incomplete Rendering Provider Data.** Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCP will be noncompliant for the measurement period.

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 MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCP 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 MCP 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 MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial

sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

vii. **NPI Provider Number Usage without Medicaid/Reporting Provider Numbers. Performance** is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCP may be determined to be noncompliant for the measurement period.

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 MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If the MCP 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 MCP 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 MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCP is in full compliance with this program requirement.

viii. **Encounter Submissions per The Ohio Department of Medicaid's Methodology for Covered Families & Children (CFC), Aged, Blind, or Disabled (ABD), and Adult Extension (Group VIII) Encounter Data Quality Measures document.** Performance is monitored once every month. If the standard is not met for the measurement period, the MCP will be noncompliant for the measurement period.

ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time the MCP 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 MCP 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 MCP if ODM determines the MCP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the financial sanction was issued.

ix. **Timeliness of Encounter Data Submission.** Performance is monitored once every month. If the standard is not met for the measurement period, the MCP will be noncompliant for the measurement period.

ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time the MCP 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 MCP 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 MCP if ODM determines the MCP is in full compliance anytime within the five consecutive report periods following the report period for which the financial sanction was issued.

15. **Quality Measures (as specified in Appendix M).** This section sets forth sanctions for those quality measure standards in Appendix M subject to corrective action.

ODM reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

For each measure in Table 1 of Appendix M, one or more rates are calculated. Each rate has an associated Minimum Performance Standard. When the MCP fails to meet a Minimum Performance Standard listed in Appendix M, for a measure for which noncompliance sanctions are applicable, the MCP may be assessed a sanction for noncompliance with the standard. ODM has established uniform noncompliance sanctions for these standards.

A series of progressive sanctions may be issued for consecutive instances of noncompliance with the standard established for a given rate. For example, four rates, corresponding to the HEDIS age breakouts, are calculated for the *Children and Adolescents' Access to Primary Care Practitioners* measure. The MCP failing

to meet the standard established for the '12-24 Months' rate in three consecutive measurement periods would be subject to progressive sanctions. However, the MCP failing to meet the standard established for the '7-11 Years' rate in one measurement period and the '12-19 Years' rate in the next would not be subject to progressive sanctions, as these only apply to the standard established for the same rate.

For the standard established for each rate listed in Table 1 of Appendix M, for measures for which noncompliance sanctions are applicable, the MCP may be assessed sanctions for instances of noncompliance as follows:

a. **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 MCP. If the MCP 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. **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 MCP. The financial sanction is non-refundable.

c. **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 MCP. The financial sanction is non-refundable.

In addition, if ODM determines the MCP is noncompliant with greater than 50% of the quality standards listed in Appendix M, for which noncompliance sanctions are applicable, for two consecutive contract years, ODM will have the option to terminate the MCP's Agreement.

16. **Quality Care (as specified in Appendix K).** 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 MCP may be required to submit a CAP as specified by ODM to remedy the identified deficiency.

b. **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, safety. This financial sanction may be imposed in accordance with ODM's Health, Safety, Welfare Improvement Process for Medicaid Managed Care Consumers.

c. **Maintenance of National Committee for Quality Assurance Health Plan Accreditation.** For the standard established in Appendix C, ODM may assess the following sanctions for noncompliance as follows:

i. **If the MCP receives a Provisional accreditation status -** the MCP will be required to complete a resurvey within 12 months of the accreditation decision. If the resurvey results in a Provisional or Denied status, ODM will consider this a material breach of this Agreement may terminate the provider agreement with the managed care plan.

ii. **If the MCP receives a Denied accreditation status** - then ODM considers this a material breach of the provider agreement and may terminate the provider agreement with the MCP.

17. **Noncompliance with Provision of Transportation Services.** If the MCP fails to comply with the transportation requirements specified in Appendix C, or if the MCP fails to transport a member to a pre-scheduled appointment on time, which results in a missed appointment, when providing Medicaid-covered transportation services and when members 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 requirements to provide Medicaid-covered transportation services.

18. **Noncompliance with Unified Preferred Drug List (UPDL) [as specified in Appendix R].** Performance with the UPDL is monitored once every calendar quarter. If the standard is not met, the MCP may be determined to be noncompliant for the measurement period. For the standard established for each quarter, the MCP may be assessed sanctions for instances of noncompliance as follows:

a. **Quarter 1 of CY 2020**. Noncompliance results for Q1 of CY 2020 will be informational only.

b. **Quarter 2 of CY2020 and any subsequent quarters**. ODM may impose a financial sanction equal to .08% of the amount calculated in accordance with this appendix for the twelve months prior to the month in which compliance is issued to the MCP. The financial sanction is nonrefundable.

19. **Noncompliance with HealthTrack complaints.** If the MCP fails to comply with the HealthTrack complaint requirements as specified in Appendix C of this Agreement, ODM may require the MCP to complete a CAP and specify the date by which compliance shall be demonstrated.

20. **Noncompliance with CSP Data Submissions.** If the MCP fails to comply with data submission requirements for reporting CSP enrollments as specified in Appendix L of this Agreement, ODM may require the MCP to complete a CAP and specify the date by which the compliance shall be demonstrated.

21. **Noncompliance with Membership Enrollment File Submissions.** If the MCP fails to comply with the data submission requirements impacting membership enrollment and reconciliation of membership enrollment, as specified in Appendices C and L of this Agreement, ODM may require the MCP to complete a CAP and specify the date by which compliance shall be demonstrated.
22. **Noncompliance with Prior Authorization requirements.**

    a. If the MCP fails to resolve at least 99% of expedited prior authorizations within the specified timelines, then ODM may impose a nonrefundable financial sanction in the amount of $10,000 for each month of noncompliance.

    b. If the MCP fails to resolve at least 99% of standard prior authorization within the specified timelines, then ODM may impose a nonrefundable financial sanction in the amount of $10,000 for each month of noncompliance.

23. **Noncompliance with Appeal Resolution requirements.**

    a. If the MCP fails to resolve at least 99% of expedited appeals within the specified timelines, then ODM may impose a nonrefundable financial sanction in the amount of $10,000 for each month of noncompliance.

    b. If the MCP fails to resolve at least 99% of standard appeals within the specified timelines, then ODM may impose a nonrefundable financial sanction in the amount of $10,000 for each month of noncompliance.

24. **Noncompliance with grievance resolution.** If the MCP fails to resolve and report at least 98% of member grievances within the specified timelines, then ODM may impose a nonrefundable financial sanction in the amount of $10,000

for each month of noncompliance.

25. **Noncompliance with Notice of Adverse Benefit Determination**. If the MC fails to provide a timely and content-compliant Notice of Adverse Benefit Determination in accordance with 5160-26-08.4, then ODM may impose a nonrefundable financial sanction in the amount of $500 per calendar day.

iii. **Financial Sanctions.** Refundable or nonrefundable financial sanctions may be assessed separately or in combination with other sanctions or remedial actions. The total financial sanctions assessed in any one month will not exceed 15% of one month's payments from ODM to the MCP. Unless otherwise stated, all financial sanctions are nonrefundable.

1. Refundable and nonrefundable financial sanctions/assurances assessed against the MCP shall be directly deducted from the net premium amount paid to the MCP. 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 MCP to ODM within 30 calendar days of invoice date by the MCP, or as otherwise directed by ODM in writing. In addition, per ORC section 131.02, payments owed to the State not received within 45 calendar days will be certified to the Attorney General's (AG's) office. The AG's Office will assess the appropriate collection fee for MCP payments certified to the AG's Office.

3. For financial sanctions calculated in accordance with this section, ODM will use the MCP'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 MCP.

4. Unless otherwise specified, any monies collected through the imposition of a refundable financial sanction will be returned to the MCP (minus any applicable collection fees owed to the AG's Office if the MCP has been delinquent in submitting payment) after it has demonstrated full compliance with the particular program requirement, as determined by ODM. Refunds will be added to the net premium amount paid to the MCP.

5. The MCP is required to submit a written request for refund to ODM at the time it believes is appropriate before a refund of monies will be considered.

6. Refundable financial sanctions issued under sections of this appendix will be returned to the MCP in the event ODM replaces or eliminates the sanction's applicable measure(s) 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 that ODM may impose on the MCP under this Agreement, ODM may prohibit the MCP from receiving new enrollment through consumer initiated selection or the assignment process if any of the following occur: (1) the MCP has accumulated a total of 51 or more points during a rolling 12-month period; (2) the MCP has failed to fully implement a plan of correction within the designated time frame; (3) circumstances exist that potentially jeopardize the MCP's members' access to care, as solely determined by ODM; or (4) the MCP is found to have a pattern of repeated or ongoing noncompliance, as solely determined by ODM. Examples of circumstances that ODM may consider as jeopardizing member access to care include, but are not limited to, the following:

1. The MCP has been found by ODM to be noncompliant with the prompt payment or the non-contracting provider payment requirements;

2. The MCP has been found by ODM to be noncompliant with the provider panel requirements specified in Appendix H;

3. The MCP has refused to comply with a program requirement after ODM has directed the MCP to comply with the specific program requirement;

4. The MCP has received notice of proposed or implemented adverse action by the ODI; or

5. The MCP has failed to provide adequate provider or administrative capacity.

Payments provided for under the Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.726.

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 the 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 MCP is determined to be in full compliance with the applicable program requirement, and the violations or deficiencies are resolved to the satisfaction of ODM.

v. **Reduction of Assignments.** ODM has discretion over how member auto-assignments are made. ODM may reduce the number of assignments the MCP receives to ensure program stability within a region, or upon a determination that the MCP lacks sufficient capacity to meet the needs of the increased enrollment volume. ODM may determine the MCP has demonstrated a lack of sufficient capacity under circumstances that include, but are not limited to the following:

1. The MCP has failed to maintain an adequate provider network;

2. The MCP has failed to provide new member materials by the member's effective date;

3. The MCP has failed to meet the minimum call center requirements;

4. The MCP has failed to meet the minimum performance standards for members with special health care needs; or

5. The MCP has failed to provide complete and accurate data files regarding appeals or grievances, primary care providers, or its Care Management System (CAMS) files.

vi. **Death or Injury to Member.** ODM may immediately terminate or suspend this Agreement if the MCP's failure to perform, or properly perform, any of the requirements in this Agreement results in the death of or serious injury to, the MCP's member, as determined by ODM.

3. **Request for Reconsiderations.** Unless otherwise specified below, the MCP may seek reconsideration of any sanction or remedial action imposed by ODM including points, financial sanctions, and member enrollment freezes. The MCP may seek reconsideration of CAPs only when a CAP is required for the first violation in a series of progressive compliance actions.

   a. The MCP may not seek reconsideration of:

      i. An action by ODM that results in changes to the auto-assignment of members; or

      ii. The imposition of directed CAPs, as defined in this appendix.

   b. The MCP shall submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:

      i. The MCP 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 MCP receives notice of the imposition of the remedial action by ODM. If ODM imposes an enrollment freeze based on access to care concerns, the enrollment freeze will be imposed concurrent with initiating notification to the MCP.

      ii. A request for reconsideration shall explain in detail why the specified sanction should not be imposed. At a minimum, the reconsideration request shall include: a statement of the proposed action being contested; the basis for requesting reconsideration; and any supporting documentation. In considering the MCP's request for reconsideration, ODM will review only the written material submitted by the MCP.

      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 MCP will be notified in writing.

iv. If ODM approves a reconsideration request, in whole, the associated sanctions or remedial actions will be rescinded. The MCP will not be required to submit a CAP.

v. If ODM approves, in part, the MCP's reconsideration request the sanction, remedial action and/ or remedial actions may be rescinded or reduced, at the discretion of ODM. The MCP may still be required to submit a CAP if ODM, in its discretion, believes that a CAP is still warranted under the circumstances.

vi. If ODM denies a reconsideration request, any CAP, sanction, or remedial action, and/or points outlined in the original notice of noncompliance will be assessed.

APPENDIX O

QUALITY WITHHOLD

1. **Quality Withhold Program.** ODM will withhold the specified percentage for the applicable SFY payout determination for use in the Quality Withhold Program. ODM will use Quality Indices or the evaluation of the MCP's response to COVID-19 to calculate the amount of the withhold payout. Quality Indices will be comprised of multiple performance measures related to the index topic. Quality Indices measure the effectiveness of the MCP's population health management strategy and quality improvement programs to impact population health outcomes. Determination of the Quality Withhold payout is specified in this appendix. A bonus pool for high performing MCPs will be established for measurement year 2019 based on unreturned quality withhold dollars as specified in this appendix

    a. **SFY 2020 Quality Withhold Payout Determination**. The Department will use the MCPs' self-reported audited HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program.

        i. **Frequency.** MCP performance will be assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2020).

        ii. **Quality Indices & Measures.** Performance will be assessed on four equally weighted Quality Indices. The Quality Indices used in the Quality Withhold program for SFY 2020 (measurement year 2019) are: (1) Chronic Condition: Cardiovascular Disease; (2) Chronic Condition: Diabetes; (3) Behavioral Health; and (4) Healthy Children. Each index is composed of multiple quality measures which are assigned different weights. The index measures and weights are described in *ODM's Quality Indices and Scoring Methodology*.

        iii. **Report Period.** The measurement year for the measures used in the Quality Indices is CY 2019.

        iv. **Index Score.** Indices will be scored according to *ODM's Quality Indices and Scoring Methodology.* A separate Index Score will be calculated for each Index.

        v. **Potential Payout.** The potential payout for this determination is equal to the amount withheld during CY 2019, i.e., ODM will withhold 2.0% of the capitation and delivery payments from January, 2019 through December, 2019.

        vi. **Calculation.** After adjusting for specific components of the MCP capitation rates as described below, ODM calculates the MCP's maximum potential payout for the Quality Indices and divides this equally among the indices used in the Quality Withhold Program. The MCP is then awarded a percentage (0-100) of the potential payout allotted to each Quality Index. This determination is made on an index-by-index basis, using the MCP's Index Score for each Quality Index in comparison to Table 3 below.

Table 1. SFY 2020 Quality Withhold Payout Table

SFY 2020 Quality Withhold Program Payout Table	
Index Score	**Percent of Potential Payout Awarded**
>=50.0	100%
45.0 – 49.9	91.6%
40.0 – 44.9	83.3%
35.0 – 39.9	75.0%
30.0 – 34.9	62.5%
25.0 – 29.9	50.0%
< 25.0	0%

In recognition of requirements in this Agreement, specified components of the MCP's capitation rate will be automatically assigned a payout award of 100%. These items include the HIC Franchise Fee, HIC tax, MCP Hospital Incentive Program, Enhanced Maternal Program, and CICIP.

vii. **SFY 2020 Bonus Pool Determination.** The SFY 2020 Bonus Pool will be funded by the unreturned SFY 2020 Quality Withhold Program dollars. If $0 are unreturned, then there will be no bonus pool. Unclaimed Bonus Pool dollars will not carry over to the next year. In order to qualify for a share of the bonus pool, MCPs must achieve the following:

1. An average Index Score of 75.0 points or greater across all indices included in the SFY 2020 Quality Withhold Program; and

2. At least 90.0% of CPC practices with MCP members attributed during the measurement year must remain in good standing on applicable quality and efficiency metrics. In order to remain in good standing, CPC practices must pass at least 50% of applicable quality metrics and at least 50% of applicable efficiency metrics. This determination will be made by ODM.

The Bonus Pool will be divided in proportion to each qualified MCP's net MMC premium and delivery payments made for the measurement year.

b. **SFY 2021 Quality Withhold Payout Determination**. The Department will use the MCPs' response to the serious public health threats posed by the spread of the 2019 Novel Coronavirus (COVID-19) for the purpose of evaluating performance related to the Quality Withhold Program.

i. **Frequency.** MCP performance will be assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2021).

ii. **Performance Evaluation.** ODM's performance evaluation will include the following:

1. **Population Health Management and Quality Improvement.**

a. An organizational structure and sufficient staffing that supports common data and quality improvement processes to advance the goals

of COVID-19-related requirements and interventions at an accelerated pace;

b. An updated Population Health Strategy for communities and health plan members in response to the public health crisis posed by the spread of COVID-19;

c. Timely implementation of COVID-19-related requirements (e.g., Appendix S and the Telehealth rule) and additional interventions needed to address the needs of members, providers, and communities;

d. Monitoring implemented COVID-19-related requirements and interventions, e.g., measuring of the effectiveness and degree of impact of interventions; and

e. Frequent identification and testing of changes to interventions needed to improve the effectiveness and impact of implemented COVID-19-related requirements and interventions.

2. **Collaboration**.

a. Collaboration with community entities;

b. Collaboration with providers, those representing providers, and/or provider associations; and

c. Collaboration with other Medicaid and non-Medicaid health plans.

3. **Results**.

a. Achieve the SMART Aim or multiple shifts in the median in the desired direction for each SMART Aim outcome measure;

b. Demonstrate that the MCP's implemented COVID-19-related requirements and interventions have broad impact on the targeted populations; and

c. Demonstrate a significant impact on disparate populations, i.e., members with geographic or racial disparities and members with a gap in access to and usage of information and communication technology (the digital divide population).

iii. **Measurement Year.** The measurement year for the performance evaluation is CY 2020.

iv. **Potential Payout.** The potential payout for this determination is equal to the amount withheld during CY 2020, i.e., ODM will withhold 3.0% of the capitation and delivery payments from January, 2020 through December, 2020.

Methods to determine the Quality Withhold payout are described in *ODM's Methodology to Determine the FY 2020 Quality Withhold Payout.*

c. **SFY 2022 Quality Withhold Payout Determination.** The Department will use the MCPs' self-reported audited HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program

i. **Frequency.** MCP performance will be assessed annually (i.e., ODM will issue one assessment and payment, if applicable, per MCP for SFY 2022).

ii. **Quality Indices & Measures.** Performance will be assessed on four weighted Quality Indices. The Quality Indices used in the Quality Withhold program for SFY 2022 (measurement year 2021) are: (1) Chronic Condition: Cardiovascular Disease; (2) Chronic Condition: Diabetes; (3) Behavioral Health; and (4) Healthy Children. Each index is composed of multiple quality measures which are assigned different weights. The index measures and weights are described in *ODM's Quality Indices and Scoring Methodology*.

iii. **Report Period.** The measurement year for the measures used in the Quality Indices is CY 2021.

iv. **Index Score.** Indices will be scored according to *ODM's Quality Indices and Scoring Methodology*. A separate Index Score will be calculated or each Index.

v. **Potential Payout:** The potential payout for this determination is equal to the amount withheld during CY 2021.

vi. **Calculation.** After adjusting for specific components of the MCP capitation rate as described below, ODM calculates the MCP's maximum potential payout for the Quality Indices and divides this equally among the four indices used in the Quality Withhold Program. The MCP is then awarded a percentage (0-100) of the potential payout allotted to each Quality Index. This determination is made on an index-by-index basis, using the MCP's Index Score for each Quality Index in comparison to Table 2 below.

Table 2. SFY 2019 Quality Withhold Payout Table.

SFY 2019 Quality Withhold Program Payout Table	
Index Score	**Percent of Potential Payout Awarded**
>=50.0	100%
45.0 – 49.9	95.0%
40.0 – 44.9	90.0%
35.0 – 39.9	85.0%
30.0 – 34.9	80.0%

25.0 – 29.9	75.0%
< 25.0	0%

In recognition of requirements in this Agreement, specified components of the MCP's capitation rate will be automatically assigned a payout award of 100%. These items include the Health Insuring Corporation (HIC) Franchise Fee, HIC tax, MCP Hospital Incentive program, Enhanced Maternal Program, and the Care Innovation and Community Improvement Program (CICIP).

vii. **SFY 2022 Bonus Pool Determination.** The SFY 2022 Bonus Pool will be funded by the unreturned SFY 2022 Quality Withhold Program dollars. If $0 are unreturned, then there will be no bonus pool. Unclaimed Bonus Pool dollars will not carry over to the next year. In order to qualify for a share of the bonus pool, MCPs must achieve the following:

1. An Index Score of 75.0 points or greater for each index included in the SFY 2022 Quality Withhold Program; and

2. At least 90.0% of CPC practices with MCP members attributed during the measurement year must remain in good standing on applicable quality and efficiency metrics. In order to remain in good standing, CPC practices must pass at least 50% of applicable quality metrics and at least 50% of applicable efficiency metrics. This determination will be made by ODM.

The Bonus Pool will be divided in proportion to each qualified MCP's net MMC premium and delivery payments made for the measurement year.

2. **Additional Operational Considerations.**

a. **Timing of Quality Withhold Program Determinations.** ODM will issue results for each Quality Withhold Program determination to participating MCPs within 12 months of the end of each established measurement period. Given that unforeseen circumstances may impact the timing of this determination, ODM reserves the right to revise the time frame in which the Quality Withhold program determination is issued (i.e., the determination may be made more than six months after the end of the contract period).

b. **Agreement Termination, Nonrenewal, or Denial.** Upon termination, nonrenewal, or denial of the MCP Agreement, the incentive or withhold amount will be retained or awarded by ODM, in accordance with Appendix P, *MCP Termination/Non-renewal,* of this Agreement.

c. **P4P or Quality Withhold Measures, Requirements, and Measurement Years.** ODM reserves the right to revise Quality Withhold measures, standards, benchmarks, requirements, and measurement years, as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's overall performance level for that contract period.

d. **Quality Withhold Program Benchmarks – Retrospective Adjustment.** ODM uses a uniform methodology, as needed, for the retrospective adjustment of any Quality Withhold Standard or Benchmark. This methodology will be implemented at ODM's sole discretion.

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 the parties.*

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX P

PLAN TERMINATIONS/NONRENEWALS

1. **MCP-Initiated Terminations/Nonrenewals.** If the MCP provides notice of the termination/nonrenewal of this Agreement to ODM, pursuant to Article VIII of the agreement, the MCP will be required to comply with the following:

    a. **Transition Plan.** Subject to ODM review and approval, the MCP shall submit a Transition Plan within 10 business days of the notice of termination/nonrenewal of this Agreement. The MCP shall make revisions to the Transition Plan as necessary to obtain ODM approval. The MCP's Transition Plan shall include the following:

        i. The MCP's agreement to comply with all duties and obligations incurred prior to the effective date of the Agreement termination/nonrenewal, including the performance of ongoing functions, and the submission of all reports and deliverables.

        ii. The identification of the MCP's Transition Coordinator, the MCP's single point of contact responsible for coordinating the MCP's transition activities.

        iii. The proposed submission timeframes for all outstanding reports and deliverables as identified by ODM.

        iv. The member outreach workflow identifying the approach and timing of outreach to members impacted by the termination/non-renewal.

        v. The MCP's communication plan, including the MCP's written notifications and proposed timeline to notify all subcontractors and members of the termination/nonrenewal. The MCP's communication plan shall include the following notifications:

            1. **Provider Notification.** The MCP 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.

            2. **Member Notification**. Unless otherwise notified by ODM, the MCP shall notify their members regarding this Agreement termination at least 45 calendar days in advance of the effective date of termination. A member outreach workflow identifying the approach and timing of outreach to members impacted must be included. The member notification shall be approved by ODM prior to distribution.

            3. **Prior Authorization Redirection Notification**. The MCP 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 MCP. The second notice is for prior authorization requests for services

to be provided before and after the effective date of termination. The MCP 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 MCP membership.

vi. The MCP's member transition of care plan including the transition of care narrative, timeline, and member services workflow to support an efficient and seamless transition of members from coverage under this Agreement to coverage under ODM's designee(s). The transition of care plan must identify at risk populations and prioritize those members. The plan must also include a newborn reconciliation approach. The prioritization and newborn reconciliation tracking must be submitted to ODM biweekly.

The MCP shall report Transition Plan updates to ODM detailing MCP progress toward completing MCP obligations under the Agreement and Transition Plan on a monthly basis, on the fifth day of the month following the month reported.

b. **Fulfill Existing Duties and Obligations**. The MCP agrees to fulfill all duties and obligations as required under Ohio Administrative Code (OAC) Chapter 5160-26 and any provider agreements related to the provision of services for the Medicaid population during periods of time when the MCP was under contract with ODM. MCP duties and obligations include the performance of ongoing functions and the submission of all outstanding reports and deliverables as identified in the Transition Plan. Specific examples of functions and reporting include, but are not limited to, the following:

i. **Member Grievances and Appeals, Provider Complaints and State Hearings.** The MCP shall resolve all provider complaints and member grievances and appeals related to the MCP's decisions and responsibilities exercised under this Agreement. The MCP shall also participate in State Hearings related thereto. The MCP must provide a monthly report of 1) member complaint, grievance, appeal and State Hearing information, and 2) provider complaint information, as outlined in the MCP's ODM-approved Transition Plan.

ii. **Claims Payment.** The MCP shall pay all outstanding obligations for services and benefits rendered to members during the period of time when the MCP was under contract with ODM in accordance with the requirements in this Agreement and OAC 5160-26-09.1. This includes, without limitation, the payment of funds owed as a result of the concurrent risk analysis process as well as the reporting, data integration, and payment requirements related to quality improvement strategies and value-based initiatives such as:

1. Principal Accountable Provider (PAP) payments (both positive and negative) based on episodes;

2. CICIP per member, per month (PMPM) and quality improvement payments; and

3. Comprehensive primary care (PCP) reimbursement activities, including shared savings.

iii. **Encounter and Claims Data.** The MCP must provide encounter data, cost report data, and claims aging reports, including incurred but not reported (IBNR) amounts, related to time periods through the final date of service every 30 calendar days as part of the monthly Transition Plan reporting requirement. Encounter reporting obligations shall continue until all services rendered prior to the termination of this Agreement have reached adjudicated status and data validation of the information has been completed.

iv. **Population Health and Performance Data**. The MCP must provide data files as specified in Appendix K, e.g., Population Stream, Risk Stratification Level, and Health Risk Assessments data, and Appendix L, e.g., MCP Self-Reported, Audited HEDIS and CAHPS data, for all periods prior to termination.

v. **Financial Reports.** The MCP shall provide financial reports as outlined in the MCP's ODM-approved Transition Plan, including:

1. Audited financial statements, inclusive of a balance sheet.

2. Reinsurance audit activities on prior contract years.

3. Finalization of any open or pending reconciliations.

The MCP will be released from its responsibilities under the Transition Plan upon ODM approval of the MCP's final report documenting that the MCP has fulfilled all outstanding obligations. The MCP will retain ongoing responsibility for providing data to support audits related to the Medicaid population served by the MCP for the MCP's Provider Agreement time periods.

c. **Cooperation.** The MCP shall fully cooperate with ODM and ODM's designee(s) to support a seamless transition of members and administrative responsibilities. The MCP shall participate in any meetings, workgroups, or other activities as requested by ODM to support the transition.

d. **Maintenance of Financial Requirements and Insurance**. The MCP shall comply with financial and insurance requirements until ODM provides the MCP written notice that all continuing obligations under this Agreement have been fulfilled.

e. **Refundable Monetary Assurance**. The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM and shall be in an amount of 5 % of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued.

The MCP 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 MCP shall contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP 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 will withhold the MCP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State.

Upon ODM's approval of the MCP's final report, ODM will refund the monetary assurance to the MCP.

f. **Quality Withhold**. Unreturned funds from the quality withhold program set forth in Appendix O of this Agreement will be retained by ODM.

g. **Final Accounting of Amounts Outstanding**. The MCP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCP. ODM payment will be limited to only those amounts properly owed by ODM.

h. **Financial sanctions**. All previously collected refundable financial sanctions shall be retained by ODM.

i. **Member Transitions.** The MCP shall conduct all member transition activities in accordance with the ODM-approved Transition Plan and in accordance with ODM requirements. When relinquishing members to ODM or ODM designee(s), the MCP is responsible for notifying ODM and/or ODM designee(s) of pertinent information related to the special needs of transitioning members. The MCP shall transfer member data to ODM and/or ODM's designee(s) within the time period and in a file format as specified by ODM.

j. **Data Files**. In order to assist members with transition and continuity of care, the MCP shall create data files to be shared with each newly enrolling ODM designee. The data files shall be provided by the MCP in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for all costs associated with data sharing and for ensuring the accuracy and data quality of the files.

2. **ODM-initiated Terminations for Cause under OAC rule 5160-26-10.**

a. If ODM initiates the proposed termination, nonrenewal or amendment of this Agreement pursuant to OAC rule 5160-26-10 by issuing a proposed adjudication order pursuant to ORC section 5164.38, and the MCP submits a valid appeal of that proposed action pursuant to ORC Chapter 119, this Agreement will be extended through the issuance of an adjudication order in the MCP's appeal under ORC Chapter 119.

During this time, the MCP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation specified in Appendix N of this Agreement. If the MCP exceeds 69 points, each subsequent point accrual will result in a $15,000 nonrefundable financial sanction.

Pursuant to OAC rule 5160-26-10, if ODM has proposed the termination, nonrenewal, denial or amendment of this Agreement, ODM may notify the MCP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCP without cause. If ODM has proposed the termination, nonrenewal, denial or amendment this Agreement, and access to medically-necessary covered services is jeopardized, ODM may propose to terminate the membership of all of the MCP's members. The appeal process for reconsideration of the proposed termination of members is as follows:

i. All notifications of such a proposed MCP membership termination will be made by ODM via certified or overnight mail to the identified MCP Contact.

ii. The MCP will be notified by ODM of such a proposed MCP membership termination, and 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 MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests shall explain in detail why the proposed MCP membership termination is not justified. The MCP's justification for reconsideration will be limited to a review of the written material submitted by the MCP.

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 MCP will be notified of such in writing.

vi. The proposed MCP membership termination will not occur while an appeal is under review and pending the Director's decision. If the Director denies the appeal, the MCP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODM determines that it would be in the best interest of the members.

b. **Transition Plan.** Subject to ODM review and approval, the MCP shall submit a Transition Plan within 10 business days of the termination of this Agreement. The MCP shall make revisions to the Transition Plan as necessary to obtain ODM approval. The MCP's Transition Plan shall include the following:

i. The MCP's agreement to comply with all duties and obligations incurred prior to the effective date of the Agreement termination, including the performance of ongoing functions as required by ODM and the submission of all reports and deliverables.

ii. The identification of the MCP's Transition Coordinator, the MCP's single point of contact responsible for coordinating the MCP's transition activities.

iii. The proposed submission timeframes for all outstanding reports and deliverables as identified by ODM.

iv. The member outreach workflow identifying the approach and timing of outreach to members impacted by the termination/non-renewal.

v. The MCP's communication plan, including the MCP's written notifications and proposed timeline to notify all subcontractors and members of the termination. The MCP's communication plan shall include the following notifications:

1. **Provider Notification.** The MCP 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.

2. **Member Notification**. Unless otherwise notified by ODM, the MCP shall notify their members regarding this Agreement termination at least 45 calendar days in advance of the effective date of termination. A member outreach workflow identifying the approach and timing of outreach to the members impacted must be included. The member notification shall be approved by ODM prior to distribution.

3. **Prior Authorization Redirection Notification**. The MCP 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 MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCP 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 MCP membership.

vi. The MCP's member transition of care plan including the transition of care narrative, timeline, and member services workflow to support an efficient and seamless transition of members from coverage under this Agreement to coverage under ODM's designee(s). The transition of care plan must identify at risk populations and prioritize those members. The plan must also include a newborn reconciliation approach. The prioritization and newborn reconciliation tracking must be submitted to ODM biweekly.

vii. The MCP shall report Transition Plan updates to ODM detailing MCP progress toward completing MCP obligations under this Agreement and Transition Plan on a monthly basis, on the fifth day of the month following the month reported.

c. **Fulfill Existing Duties and Obligations**. The MCP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-26 and any provider agreements related to the provision of

services for the Medicaid population during periods of time when the MCP was under contract with ODM. Such duties and obligations include the performance of ongoing functions and the submission of all outstanding reports and deliverables as identified in the Transition Plan. Specific examples of functions and reporting include:

i. **Member Grievances and Appeals, Provider Complaints and State Hearings**. The MCP shall resolve all provider complaints and member grievances and appeals related to the MCP's decisions and responsibilities exercised under the Contract. The MCP shall also participate in State Hearings related thereto. The MCP must provide a monthly report of 1) member complaint, grievance, appeal and State Hearing information, and 2) provider complaint information, as outlined in the MCP's ODM-approved Transition Plan.

ii. **Claims Payment.** The MCP shall pay all outstanding obligations for services and benefits rendered to member during the period of time when the MCP was under contract with ODM in accordance with the requirements in this Agreement and OAC 5160-26-09.1. This includes, without limitation, the payment of funds owed as a result of the concurrent risk analysis process as well as the reporting, data integration, and payment requirements related to quality improvement strategies and value-based initiatives such as:

1. Principal Accountable Provider (PAP) payments (both positive and negative) based on episodes;

2. CICIP per member, per month (PMPM) and quality improvement payments; and

3. Comprehensive primary care (PCP) reimbursement activities, including shared savings.

iii. **Encounter and Claims Data.** The MCP must provide encounter data, cost report data, and claims aging reports, IBNR amounts, related to time periods through the final date of service every 30 calendar days as part of the monthly Transition Plan reporting requirement. Encounter reporting obligations shall continue until all services rendered prior to the termination of this Agreement have reached adjudicated status and data validation of the information has been completed.

iv. **Population Health and Performance Data**. The MCP must provide data files as specified in Appendix K, e.g., Population Stream, Risk Stratification Level, and Health Risk Assessments data, and Appendix L, e.g., MCP Self-Reported, Audited HEDIS and CAHPS data, for all periods prior to termination.

v. **Financial Reports.** The MCP shall provide financial reports as outlined in the MCP's ODM-approved Transition Plan, including:

1. Audited financial statements, inclusive of a balance sheet.

2. Reinsurance audit activities on prior contract years.

3. Finalization of any open or pending reconciliations.

vi. The MCP will be released from its responsibilities under the Transition Plan upon ODM approval of the MCP's final report documenting that the MCP has fulfilled all outstanding obligations. The MCP will retain ongoing responsibility for providing data to support audits related to the Medicaid population served by the MCP for the MCP's Provider Agreement time periods.

d. **Cooperation.** The MCP shall fully cooperate with ODM and ODM's designee(s) to support a seamless transition of members and administrative responsibilities. The MCP shall participate in any meetings, workgroups, or other activities as requested by ODM to support the transition.

e. **Maintenance of Financial Requirements and Insurance.** The MCP shall comply with financial and insurance requirements until ODM provides the MCP written notice that all continuing obligations under this Agreement have been fulfilled.

f. **Refundable Monetary Assurance**. The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM and shall be in an amount of 5 % of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued.

The MCP 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 MCP shall contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP 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 will withhold the MCP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State.

Upon ODM's approval of the MCP's final report, ODM will refund the monetary assurance to the MCP.

g. **Quality Withhold**. Unreturned funds from the quality withhold program set forth in Appendix O of this Agreement will be retained by ODM.

h. **Financial Sanctions**. All previously collected refundable financial sanctions shall be retained by ODM.

i. **Final Accounting of Amounts Outstanding**. The MCP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCP. ODM payment will be limited to only those amounts properly owed by ODM.

j. **Member Transitions.** The MCP shall conduct all member transition activities in accordance with the ODM-approved Transition Plan and in accordance with ODM requirements. When relinquishing members to ODM or ODM designee(s), the MCP is responsible for notifying ODM and/or ODM designee(s) of pertinent information related to the special needs of transitioning members. The MCP shall transfer member data to ODM and/or ODM's designee(s) within the time period and in a file format as specified by ODM.

k. **Data Files**. In order to assist members with transition and continuity of care, the MCP shall create data files to be shared with each newly enrolling ODM designee. The data files shall be provided by the MCP in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for all costs associated with data sharing and for ensuring the accuracy and data quality of the files.

3. **Termination due to Non-selection through ODM Procurement Processes.** Should this Agreement end or not be extended in the event the MCP is not awarded a provider agreement as a result of an ODM procurement and selection process, the MCP 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. **Transition Plan.** Subject to ODM review and approval, the MCP shall submit a Transition Plan within 10 days of the MCP receiving notification that the MCP was not selected as a contractor as a result of a procurement process (expiration). The MCP shall make revisions to the Transition Plan as necessary to obtain ODM approval. The MCP's Transition Plan shall include the following:

i. The MCP's agreement to comply with all duties and obligations incurred prior to the effective date of the Agreement termination due to non-selection, including the performance of ongoing functions, and the submission of all reports and deliverables.

ii. The identification of the MCP's Transition Coordinator, the MCP's single point of contact responsible for coordinating the MCP's transition activities.

iii. The proposed submission timeframes for all outstanding reports and deliverables as identified by ODM.

iv. The member outreach workflow identifying the approach and timing of outreach to members impacted by the termination/nonrenewal.

v. The MCP's communication plan, including the MCP's written notifications and proposed timeline to notify all subcontractors and members of the termination. The MCP's communication plan shall include the following notifications:

1. **Provider Notification.** The MCP 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.

2. **Member Notification**. Unless otherwise notified by ODM, the MCP shall notify their members regarding this Agreement termination at least 45 calendar days in advance of the effective date of termination. A member outreach workflow identifying the approach and timing of outreach to the members impacted must be included. The member notification shall be approved by ODM prior to distribution.

3. **Prior Authorization Redirection Notification**. The MCP 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 MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCP 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 MCP membership.

vi. The MCP's member transition of care plan including the transition of care narrative, timeline, and member services workflow to support an efficient and seamless transition of members from coverage under this Agreement to coverage under any new arrangement developed by ODM. The transition of care plan must identify at risk populations and prioritize those members. The plan must also include a newborn reconciliation approach. The prioritization and newborn reconciliation tracking must be submitted to ODM biweekly.

vii. The MCP shall report Transition Plan updates to ODM detailing MCP progress toward completing MCP obligations under the Agreement and Transition Plan on a monthly basis, on the fifth day of the month following the month reported.

b. **Fulfill Existing Duties and Obligations**. The MCP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-26 and any provider agreements related to the provision of services for the Medicaid population during periods of time when the MCP was under contract with ODM. MCP duties and obligations include, the performance of ongoing functions and the submission of all outstanding reports and deliverables as identified in the Transition Plan. Specific examples of functions and reporting include, but are not limited to, the following:

i. **Member Grievances and Appeals, Provider Complaints and State Hearings.** The MCP shall resolve all provider complaints and member grievances and appeals related to the MCP's decisions and responsibilities exercised under this Agreement. The MCP shall also participate in State Hearings related thereto. The MCP must provide a monthly report of 1) member complaint, grievance, appeal and State Hearing information, and 2) provider complaint information, as outlined in the MCP's ODM-approved Transition Plan.

ii. **Claims Payment.** The MCP shall pay all outstanding obligations for services and benefits rendered to member during the period of time when the MCP was under contract with

ODM in accordance with the requirements in this Agreement and OAC 5160-26-09.1. This includes, without limitation, the payment of funds owed as a result of the concurrent risk analysis process as well as the reporting, data integration, and payment requirements related to quality improvement strategies and value-based initiatives such as:

1. Principal Accountable Provider (PAP) payments (both positive and negative) based on episodes;

2. CICIP per member, per month (PMPM) and quality improvement payments; and

3. Comprehensive primary care (PCP) reimbursement activities, including shared savings.

iii. **Encounter and Claims Data.** The MCP must provide encounter data, cost report data, and claims aging reports, including IBNR amounts, related to time periods through the final date of service every 30 calendar days as part of the monthly Transition Plan reporting requirement. Encounter reporting obligations shall continue until all services rendered prior to the termination of this Agreement have reached adjudicated status and data validation of the information has been completed.

iv. **Population Health and Performance Data**. The MCP must provide data files as specified in Appendix K, e.g., Population Stream, Risk Stratification Level, and Health Risk Assessments data, and Appendix L, e.g., MCP Self-Reported, Audited HEDIS and CAHPS data, for all periods prior to termination.

v. **Financial Reports.** The MCP shall provide financial reports as outlined in the MCP's ODM-approved Transition Plan, including:

1. Audited financial statements, inclusive of a balance sheet.

2. Reinsurance audit activities on prior contract years.

3. Finalization of any open or pending reconciliations.

vi. The MCP will be released from its responsibilities under the Transition Plan upon ODM approval of the MCP's final report documenting that the MCP has fulfilled all outstanding obligations. The MCP will retain ongoing responsibility for providing data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

c. **Cooperation.** The MCP shall fully cooperate with ODM and ODM's designee(s) to support a seamless transition of members and administrative responsibilities. The MCP shall participate in any meetings, workgroups, or other activities as requested by ODM to support the transition.

d. **Maintenance of Financial Requirements and Insurance.** The MCP shall comply with financial and insurance requirements until ODM provides the MCP written notice that all continuing obligations under this Agreement have been fulfilled.

e. **Refundable Monetary Assurance**. The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM and shall be in an amount of 5% of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued.

   The MCP 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 MCP shall contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP 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 will withhold the MCP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State.

   Upon ODM's approval of the MCP's final report, ODM will refund the monetary assurance to the MCP.

f. **Quality Withhold**. Unreturned funds from the quality withhold program set forth in Appendix O of this Agreement will be retained by ODM.

g. **Financial sanctions**. All previously collected refundable financial sanctions shall be returned to the MCP upon ODM's approval of the MCP's final report documenting that the MCP has timely fulfilled all outstanding obligations.

h. **Final Accounting of Amounts Outstanding**. The MCP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCP. ODM payment will be limited to only those amounts properly owed by ODM.

i. **Member Transitions.** The MCP shall conduct all member transition activities in accordance with the ODM-approved Transition Plan and in accordance with ODM requirements. When relinquishing members to ODM or ODM designee(s), the MCP is responsible for notifying ODM and/or ODM designee(s) of pertinent information related to the special needs of transitioning members. The MCP shall transfer member data to ODM and/or ODM's designee(s) within the time period and in a file format as specified by ODM.

j. **Data Files**. In order to assist members with transition and continuity of care, the MCP shall create data files to be shared with each newly enrolling ODM designee. The data files shall be provided by the MCP in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments,

and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for all costs associated with data sharing and for ensuring the accuracy and data quality of the files.

4. **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 MCP 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. **Transition Plan.** Subject to ODM review and approval, the MCP shall submit a Transition Plan within 10 days of the MCP receiving notification of termination or modification of this Agreement due to lack of funding. The MCP shall make revisions to the Transition Plan as necessary to obtain ODM approval. The MCP's Transition Plan shall include the following:

        i. The MCP's agreement to comply with all duties and obligations incurred prior to the effective date of the Agreement termination or modification, including the performance of ongoing functions as identified by ODM, and the submission of all reports and deliverables.

        ii. The identification of the MCP's Transition Coordinator, the MCP's single point of contact responsible for coordinating the MCP's transition activities.

        iii. The proposed submission timeframes for all outstanding reports and deliverables as identified by ODM.

        iv. The member outreach workflow identifying the approach and timing of outreach to members impacted by the termination/non-renewal.

        v. The MCP's communication plan, including the MCP's written notifications and proposed timeline to notify all subcontractors and members of the termination. The MCP's communication plan shall include the following notifications:

            1. **Provider Notification.** The MCP 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.

            2. **Member Notification**. Unless otherwise notified by ODM, the MCP shall notify their members regarding this Agreement termination at least 45 calendar days in advance of the effective date of termination. A member outreach workflow identifying the approach and timing of outreach to the members impacted must be included. The member notification shall be approved by ODM prior to distribution.

            3. **Prior Authorization Redirection Notification**. The MCP 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 MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCP 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 MCP membership.

vi. The MCP's member transition of care plan including the transition of care narrative, timeline, and member services workflow to support an efficient and seamless transition of members from coverage under this Agreement to coverage under any new arrangement developed by ODM. The transition of care plan must identify at risk populations and prioritize those members. The plan must also include a newborn reconciliation approach. The prioritization and newborn reconciliation tracking must be submitted to ODM biweekly.

vii. The MCP shall report Transition Plan updates to ODM detailing MCP progress toward completing MCP obligations under the Agreement and Transition Plan on a monthly basis, on the fifth day of the month following the month reported.

b. **Fulfill Existing Duties and Obligations.** The MCP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-26 and any provider agreements related to the provision of services for the Medicaid population(s) during periods of time when the MCP was under contract with ODM. Such duties and obligations include, but the performance of ongoing functions and the submission of all outstanding reports and deliverables as identified in the Transition Plan. Specific examples of functions and reporting include, but are not limited to, the following:

i. **Member Grievances and Appeals, Provider Complaints and State Hearings.** The MCP shall resolve all provider complaints and member grievances and appeals related to the MCP's decisions and responsibilities exercised under the Contract. The MCP shall also participate in State Hearings related thereto. The MCP must provide a monthly report of 1) member complaint, grievance, appeal and State Hearing information, and 2) provider complaint information, as outlined in the MCP's ODM-approved Transition Plan.

ii. **Claims Payment.** The MCP shall pay all outstanding obligations for services and benefits rendered to member during the period of time when the MCP was under contract with ODM in accordance with the requirements in this Agreement and OAC 5160-26-09.1. This includes, without limitation, the payment of funds owed as a result of the concurrent risk analysis process as well as the reporting, data integration, and payment requirements related to quality improvement strategies and value-based initiatives such as:

1. Principal Accountable Provider (PAP) payments (both positive and negative) based on episodes;

2. CICIP per member, per month (PMPM) and quality improvement payments; and

3. Comprehensive primary care (PCP) reimbursement activities, including shared savings.

iii. **Encounter and Claims Data.** The MCP must provide encounter data, cost report data, and claims aging reports, including IBNR amounts, related to time periods through the final date of service every 30 calendar days as part of the monthly Transition Plan reporting requirement. Encounter reporting obligations shall continue until all services rendered prior to the termination of this Agreement have reached adjudicated status and data validation of the information has been completed.

iv. **Population Health and Performance Data**. The MCP must provide data files as specified in Appendix K, e.g., Population Stream, Risk Stratification Level, and Health Risk Assessments data, and Appendix L, e.g., MCP Self-Reported, Audited HEDIS and CAHPS data, for all periods prior to termination. **Financial Reports.** The MCP shall provide financial reports as outlined in the MCP's ODM-approved Transition Plan, including:

1. Audited financial statements, inclusive of a balance sheet.

2. Reinsurance audit activities on prior contract years.

3. Finalization of any open or pending reconciliations.

v. The MCP will be released from its responsibilities under the Transition Plan upon ODM approval of the MCP's final report documenting that the MCP has fulfilled all outstanding obligations. The MCP will retain ongoing responsibility for providing data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

c. **Cooperation.** The MCP shall fully cooperate with ODM and ODM's designee(s) to support a seamless transition of members and administrative responsibilities. The MCP shall participate in any meetings, workgroups, or other activities as requested by ODM to support the transition.

d. **Maintenance of Financial Requirements and Insurance**. The MCP shall comply with financial and insurance requirements until ODM provides the MCP written notice that all continuing obligations under this Agreement have been fulfilled.

e. **Refundable Monetary Assurance**. The MCP will be required to submit a refundable monetary assurance should the Agreement terminate. This monetary assurance will be held by ODM and shall be in an amount of 5 % of the capitation amount paid by ODM in the month the termination notice is issued.

The MCP 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 MCP shall contact

their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices shall be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP 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 will withhold the MCP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State.

Upon ODM's approval of the MCP's final report, ODM will refund the monetary assurance to the MCP.

f. **Quality Withhold**. Unreturned funds from the quality withhold program set forth in Appendix O of this Agreement will be retained by ODM.

g. **Financial sanctions**. Previously collected refundable financial sanctions directly and solely related to the termination or modification of this Agreement shall be returned to the MCP upon ODM's approval of the MCP's final report documenting that the MCP has timely fulfilled all outstanding obligations.

h. **Final Accounting of Amounts Outstanding**. The MCP shall submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after a termination/nonrenewal date of this Agreement. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCP. ODM payment will be limited to only those amounts properly owed by ODM.

i. **Member Transitions.** The MCP shall conduct all member transition activities in accordance with the ODM-approved Transition Plan and in accordance with ODM requirements. When relinquishing members to ODM or ODM designee(s), the MCP is responsible for notifying ODM and/or ODM designee(s) of pertinent information related to the special needs of transitioning members. The MCP shall transfer member data to ODM and/or ODM's designee(s) within the time period and in a file format as specified by ODM.

j. **Data Files**. In order to assist members with transition and continuity of care, the MCP shall create data files if requested by ODM. The data files shall be provided by the MCP in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The MCP will be responsible for all costs associated with data sharing and for ensuring the accuracy and data quality of the files.

The sanctions for noncompliance 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 MCP shall support and advance initiatives where payment for Medicaid managed care is increasingly designed to improve and reflect the effectiveness and efficiency with which providers deliver care. The MCP 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 MCP shall achieve progress in the following areas:

    a. **Value-Oriented Payment**. The MCP 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. elective cesarean deliveries). Value is defined as the level of the quality of care for the amount of money paid to the provider. Payments designed to reflect value are those 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 MCP shall design contracting methodologies and payment options and administer the benefit package to members in a manner that enhances competition among providers and reduces unwarranted price and quality variation. To stimulate provider competition further, the MCP shall establish programs to engage members to make informed choices and to select evidence-based, cost-effective care.

    c. **Transparency**. The MCP shall participate in ODM initiatives to design and implement member-accessible comparisons of provider information including quality, cost, and patient experience among providers in the MCP's network. The MCP shall contribute to the program design, provide data as specified by ODM, and publish results in accordance with standards established by the Department.

2. The MCP shall provide ODM with its strategy to make 50% of aggregate net payments to providers value-oriented by 2020. In addition, the MCP shall submit a quarterly progress report as specified by ODM that addresses progress towards meeting these obligations. Implementation strategies include the following:

    a. Pay providers differentially according to performance (and reinforce with benefit design);

    b. Design approaches to payment that reduce waste while not diminishing quality, including reducing unwarranted payment variation;

c. Design payments to encourage adherence to clinical guidelines. At a minimum, the MCP shall address policies to discourage elective deliveries before 39 weeks; and

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). Prior to implementation, the MCP shall inform ODM of service specific fee schedule changes that may adversely impact 50 or more network providers.

3. The MCP shall implement value-based initiatives in accordance with Ohio Administrative Code rules 5160-1-70, 5160-1-71, and 5160-1-72. In the event the MCP has data quality errors with episodes reporting which causes significant errors, as determined by ODM, the MCP shall pay applicable positive payments; however, the MCP shall not collect the negative payments. Significant errors may include, but are not limited to, encounter data errors that lead to episodes misattributed to Principle Accounting Providers, encounter data errors that lead to incorrect quality metric results for those tied to payment, large amounts of missing encounter data that cause misleading or delayed reports, etc. Episodes positive and negative payments must be paid within 180 calendar days of when the provider receives the episodes report.

4. **Reporting.** The MCP 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;

   f. Sum of total net payments; and

   g. Unique count of members.

5. **Care Innovation and Community Improvement Program (CICIP) Requirements.** CICIP was developed to increase alignment of quality improvement strategies and goals between ODM, the MCP, and both public and nonprofit hospital agencies. The four hospital agencies are large Medicaid safety-net and academic medical centers. CICIP goals align with ODM goals: improve healthcare for Medicaid beneficiaries at risk of or with an opioid or other substance abuse disorder, along with improving care coordination.

ODM's actuary will estimate a per member per month (PMPM) amount associated with CICIP. This amount will be reduced by a predetermined percentage, with the difference being allocated to annual bonus payments based on adherence to data reporting requirements and achievement of performance improvements. The estimated CICIP payment, less the amount allocated to bonus payments, will be included in the capitation rates with each program year. The capitation rates will include a fixed PMPM amount for CICIP, with potential variation by region and rate cell. The MCP monthly payments equal to the CICIP PMPM amounts included in the capitation rates will then be allocated to the agencies based on historical Medicaid utilization. ODM will notify the MCP on the payment amount for each agency based on the agreed upon payment schedule with the agencies.

ODM will calculate the bonus payments to the agencies based on the agreed upon value based/ quality measures. ODM will provide the bonus payments to the MCP so it can be distributed to the agencies.

As the program moves forward, CICIP PMPM allocations by practice will be reconciled based on actual utilization, and future payments are adjusted based on a semi-annual process. The CICIP payments included in the capitation rates are anticipated to be updated annually, with the option for mid-year amendments.

a. **Participating Agencies**. For the purpose of this requirement, a participating agency is defined as either a public hospital agency as defined in ORC section 140.01, or a nonprofit hospital agency as defined in ORC section 140.01 that is affiliated with a state university as defined in ORC section 3345.011. The participating agencies are:

    i. The MetroHealth System,

    ii. UC Health,

    iii. University of Toledo Medical Center,

    iv. The Ohio State University Wexner Medical Center.

b. **Qualified Practitioners**. For the purposes of the CICIP program, qualified practitioners include: Physicians, Physician Assistants, Nurse Practitioner (NPs), Clinical Nurse Specialist (CNSs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives (CNMs), Clinical Social Workers (CSWs), Clinical Psychologists, Optometrists, and Dentists. The services for the professionals listed would be billed under one of the Group national provider identifier (NPI) numbers that are affiliated with one of the Participating Agencies and identified by ODM.

c. **Reporting.** CICIP payments will be based on the HIPAA compliant 820 file. Encounter claims data will be used for the appropriate time period when calculating CICIP payments and reconciling previous payment.

d. **Quality Measures.** The quality measures that were agreed upon between ODM, the MCP, and the agencies are as follows:

i. Rate of Opioid Solid Doses Dispensed (without Suboxone) per patients of practitioners prescribing opiates;

ii. Rate of patients receiving opioids also receiving benzodiazepines;

iii. Rate of patients receiving greater than 80 mg Morphine Equivalent Dose (MED) of patients with opioid scripts;

iv. Initiation and Engagement of Alcohol and other Drug Dependence (HEDIS);

v. Follow-up after inpatient stay for mental health within 7 days (HEDIS);

vi. Emergency Room Utilization Reduction; and

vii. Improve the Opioid Use Disorder (OUD)/maternity measures with a focus on:

1. Timeliness of prenatal care;

2. Live births weighing less than 2,500 grams; and

3. Postpartum care.

CICIP will not have an impact on Comprehensive Primary Care (CPC). The payments to the MCP for CICIP will not be included when calculating CPC.

HIC Tax amounts included in each program year's capitation rates will be increased to account for CICIP.

ODM will provide the MCP advance notice of when the payment will be due and the amount of the payment to the CICIP participating agencies.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX R

PHARMACY SERVICES

1. **Prescribed Drugs.**

   a. In providing the Medicaid pharmacy benefit to their members, the MCP shall adhere to the Medicaid Unified Preferred Drug List (UPDL) and cover:

      i. The same drugs covered by the FFS program, in accordance with OAC rules 5160-26-03 and 5160-9-03, unless otherwise specified by ODM; and

      ii. All Covered Outpatient Drugs, as defined in in Section 1927(k) of the Social Security Act, marketed by a drug manufacturer (or labeler) that participates in the Medicaid Drug Rebate Program within ten calendar days of the drug's availability in the marketplace.

      Adherence requirements with the UPDL is specified in ODM's Unified PDL Adherence Methodology and Compliance document.

   b. ODM may specify carve-out of selected medications from MCPs. Carved-out medications will be covered under the Medicaid fee-for-service benefit. A current listing of these medications is located at https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans#1910241-guidance. Notification of ODM's intent to carve-out a medication will be made to plans at least 30 calendar days prior to implementation. Regardless of the setting and the payer (FFS or Managed Care), these medications must be prior authorized through FFS. The approved prior authorization will be shared with the appropriate MCP for care management purposes. Carved out medications will not be included in capitation rates and the MCP will continue to be responsible for any and all medically necessary costs associated with the administration and/or monitoring of any of these medications.

   c. The MCP shall convene with ODM, at a minimum quarterly, to review new drugs to market and proposed prior authorization criteria. These considerations shall be presented to the ODM Pharmacy & Therapeutics (P&T) Committee, operating under ORC section 5164.7510, which meets quarterly. The MCP shall convene with ODM at a minimum annually to review the entire Unified Preferred Drug List (PDL) document and prior authorization criteria. These considerations shall be presented to the ODM P&T Committee annually.

   d. The MCP shall pay an administration fee at the point-of-sale to pharmacists administering drugs by injection as allowed per OAC rule 4729-5-40.

   e. The MCP shall provide members with a printed version of the UPDL and prior authorization lists upon request.

   f. The MCP shall continue to work with ODM to create a consistent utilization management and prior authorization approach for all opioids and Medication Assisted Treatment (MAT).

g. The MCP shall use the Limitations of Coverage and Drug Use Programs as set forth in 1927(d) and (g) of the Social Security Act and other requirements as specified in this Agreement or as otherwise approved by ODM to limit prescribed drugs. Other strategies the MCP may use include, but are not limited to:

    i. Limits on quantity, age, and/or clinical requirements except where specified by the UPDL;

    ii. Step therapy protocols or programs. Step therapy protocols or programs implemented by the MCP shall be in compliance with ORC 3901.83 to 3901.833;

    iii. Blocking payments to pharmacies for drugs prescribed by a particular non-panel provider, if the MCP has done all of the following:

        1. Referred the prescriber to ODM Program Integrity for suspicion of fraud, waste, or abuse.

        2. Determined that the prescriber is not an employee of a Federally Qualified Health Center, Rural Health Clinic, Qualified Family Planning Provider, emergency department, or Ohio MHAS-certified Community Mental Health Center or Substance Use Disorder provider.

        3. Notified members who received prescriptions, within the previous 90 calendar days, from that provider, that prescriptions from the prescriber will no longer be covered and ensured members have future access to a prescriber of the same specialty.

h. The MCP shall comply with ORC section 5160.34 regarding prior authorization requirements.

i. The MCP shall comply with ORC section 5164.7511 regarding medication synchronization.

j. Pursuant to subsection 1902(a)(85) of the Social Security Act [42 U.S.C. 1396a(a)(85)], and as specified by ODM, the MCP is required to have a claims review process or program that:

    i. Has safety edits regarding subsequent fills for opioids prescribed in excess of any limitation identified by the State;

    ii. Has safety edits on the maximum daily morphine equivalents able to be prescribed to an individual enrolled in MCP for the treatment of chronic pain;

    iii. Monitors individuals enrolled in the MCP that are concurrently prescribed opioids and benzodiazepines or antipsychotics;

    iv. Monitors and manages the appropriate use of antipsychotic medications by children enrolled in the MCP and submits information to the Secretary activities under programs for individuals under the age of 18 years and children in foster care as requested

annually; and

v. Identifies potential fraud or abuse of controlled substances by individuals enrolled in the MCP.

j. The MCP shall, at a minimum, ensure same day coverage of the first dose of a long-acting injectable opioid antagonist for substance use disorders.

k. The MCP shall report the following information to ODM upon request:

i. The top 25 drugs by total net cost after any discount and rebates are applied; and

ii. The top 25 drugs by highest percent increase in price paid per unit to the MCP's pharmacies based upon average price in the quarter being reported compared to the previous quarter.

2. **Pharmaceutical Drug Reporting and Pricing Requirements.**

a. **Drug Rebates**. Section 1927 of the Social Security Act, 42 U.S.C. 1396r-8, mandates that drug companies or labelers shall sign a Medicaid Drug Rebate Agreement with the federal government to provide federal drug rebates to the State in order to have their products covered by the Medicaid Program. Additionally, the Affordable Care Act (ACA) requires ODM to obtain federal drug rebates for drugs paid for by the MCPs. In order to ensure compliance with federal law, the MCP shall:

i. Report the necessary encounter data to ODM for the invoicing of manufacturer rebates for all Covered Outpatient Drugs. This includes physician-administered drugs, drugs personally furnished by a physician, drugs provided in clinics and non-institutional settings, drugs dispensed by 340B covered entities, and drugs dispensed to MCP members with private or public pharmacy coverage and the MCP provided secondary coverage.

ii. Work cooperatively with ODM and its designees, providing ODM with sufficient data and information to enable ODM to secure federal drug rebates for all utilization and administration of Covered Outpatient Drugs as described above. The MCP shall also assist ODM and its designees with the resolution of drug manufacturer disputes regarding claims for federal drug rebates for drugs dispensed or administered to MCP Members.

iii. Report Covered Outpatient Drug utilization information that is necessary for ODM to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Act no later than 45 calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each Covered Outpatient Drug dispensed or covered by the MCP.

iv. Establish Medicaid-specific Bank Identification Number (BIN) and Processor Control

Number (PBN) numbers for point-of-sale pharmacy claims processing, to ensure that the MCP's BIN and PCN numbers for Medicaid are not the same as for the MCP's commercial or Medicare part D business lines. This information shall be provided to ODM on a quarterly basis.

v. Report all Covered Outpatient Drug information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by ODM. The MCP is prohibited from negotiating their own supplemental rebates for pharmaceutical products listed on the UPDL with drug manufacturers.

vi. Report all drugs billed to the MCP that were acquired through the 340B drug pricing program using standard modifiers so they can be properly excluded from federal drug rebates. The MCP shall accommodate for the reporting of an SE modifier with drugs acquired through the 340B Drug Pricing Program.

b. **Average Wholesale Price (AWP)**. If the basis of drug pricing is determined by AWP, then the MCP shall require the PBM to utilize a nationally recognized AWP source (e.g. Medi-Span). AWP shall mean and refer to a covered prescription service based on pricing files received by the PBM from a nationally recognized source as updated at least every seven days.

c. **Maximum Allowable Cost (MAC) Pricing**. The MCP shall update maximum allowable cost (MAC) and other pricing benchmarks on a schedule at least as consistent as is required by CMS for Medicare Part D plans found in 42 CFR 423.505(b)(21) (e.g. every 7 calendar days). Upon request from ODM or a retail pharmacy in Ohio, the MCP shall provide at least one source where a non-340B retail community pharmacy in Ohio is able to purchase the drug at the MCP's MAC rate for that drug, or lower. The MCP shall provide a reasonable and direct process for Ohio's retail community pharmacies to communicate with the MCP and report the pharmacy's inability to purchase at the MCP's MAC price and receive instructions form the MCP as to where to purchase at the MAC price.

d. **Pricing Schedule Transparency**. If the MCP has an agreement or contract with a pharmacy benefit manager (PBM) or a pharmacy benefit administrator (PBA), the PBM or PBA shall use the same pricing schedule to reimburse pharmacies and to charge the MCP. At least semi-annually, the MCP shall review the PBM or PBA's pricing structure.

3. **Drug Utilization Management**. The MCP shall operate a drug utilization review (DUR) program and DUR Board designed to promote the appropriate clinical prescribing of covered drugs that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 CFR Part 456 subpart K. As specified by ODM, the MCP shall submit information to fulfill the requirements of the annual report detailed in 42 CFR 456.712 of subpart K, including a detailed description of the program as required by 42 CFR 438.3(s)(5). Pursuant to ORC section 5167.12, the MCP may implement strategies for the management of drug utilization. ODM may request details of drug utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. and require changes to such programs, if they cause barriers to care. The MCP may, subject to ODM prior-approval, place limitations on the type of provider and locations where certain drugs may be administered; however, the MCP cannot require PA for drugs used to prevent preterm birth nor can they require PA

for the location of administration (e.g., home or office). The MCP shall establish their PA system so that it does not unnecessarily impede member access to medically-necessary Medicaid-covered services as follows:

a. As outlined in Appendix C, the MCP shall adhere to specific PA limitations to assist with the transition of new members from FFS Medicaid.

b. As outlined in ORC section 5167.12, the MCP is prohibited from requiring prior authorization (PA) in the case of a drug to which all of the following apply:

   i. The drug is an antidepressant or antipsychotic;

   ii. The drug is administered or dispensed in a standard tablet or capsule form, except that in the case of an antipsychotic, the drug also may be administered or dispensed in a long-acting injectable form;

   iii. The drug is prescribed by any of the following:

      1. An MCP panel provider psychiatrist; or

      2. A psychiatrist practicing at a location on behalf of a CMHC; or

      3. A certified nurse practitioner or clinical nurse specialist who is certified in psychiatric mental health by a national certifying organization;

   iv. The drug is prescribed for a use indicated on the drug's labeling, as approved by the federal food and drug administration.

   The MCP may require PA for antidepressant or antipsychotic drugs that do not meet the criteria outlined above. The MCP shall take into consideration the prescribing provider's verification that the member is stable on the specific medication when making the PA decision.

c. The MCP shall comply with the provisions of 1927(d)(5) of the Social Security Act, 42 USC 1396r-8(d)(5), 42 CFR 438.3(s)(6), and OAC rule 5160-26-03.1 regarding the timeframes for prior authorization of Covered Outpatient Drugs, including physician administered drugs.

d. **Coordinated Services Program (CSP).** The MCP shall develop and submit for prior approval, a CSP as defined in OAC rule 5160-20-01 to address the overuse or misuse of services. The MCP shall, at a minimum, follow all provisions set forth in OAC rule 5160-20-01 for initial and continued enrollment in the CSP program. The MCP shall offer to provide care management services to any member who is enrolled in the CSP.

e. **Medication Therapy Management (MTM) Program.** MTM is a process that promotes safe and effective use of medications, including prescription and over the counter drugs, vitamins, and herbal supplements.

i. The MCP shall implement an MTM program that shall be submitted and approved annually as directed by ODM. The MCP's MTM program shall detail the MTM triggering events, activity that occurs after a triggering event, how each MTM interaction is documented and reimbursed, and how an action plan will be initiated and monitored.

ii. The MCP's MTM program shall utilize community pharmacists or other qualified providers to render MTM services.

iii. The MCP shall report quarterly to ODM the key utilization and financial metrics for their MTM program.

iv. The MCP shall develop, but is not limited to, MTM services focused on Opioid Services, Pediatrics, and Behavioral Health.

1. The Opioid Services shall be, but are not limited to, initiatives focused on the education and safe use of opioids as well as the proper disposal of opioids.

2. The Pediatric Services shall be, but are not limited to, initiatives focused on immunizations, asthma therapy, and treatment of upper respiratory infections.

3. The Behavioral Health Services shall be, but are not limited to, initiatives focused on the use of antipsychotic medications.

4. The MCP shall collaborate with ODM during calendar year 2020 to design requirements for a Public Children Services Association (PCSA) requested targeted medication review process for children in custody to be effective on or after January 1, 2021 as specified by ODM.

5. The MCP will coordinate Prospective and Retrospective Drug Utilization Review strategies with ODM as specified.

4. **Pharmacies Embedded within Comprehensive Primary Care (CPC) Practice Sites.** When the MCP is contracted with a CPC that has a physically embedded Medicaid-enrolled pharmacy at one or more practice sites, the MCP shall, in good faith effort, offer a contract to the pharmacy to enter into their panel with terms no less favorable than existing pharmacy arrangements to allow for appropriate medication management for members. MCPs must provide reimbursement for CPC-embedded pharmacies for providing Medication Therapy Management through an established third party program.

5. **Alternative Strategies for 340B Entities**. ODM is working toward implementing alternative strategies for 340B entities, and the MCP shall collaborate with ODM and implement the policy by a date specified by ODM.

6. **Pharmacy Benefit Manager (PBM) Agreements**. In addition to the subcontractual relationships and delegation requirements listed in Appendix C of this Agreement, if the MCP enters into a contract or agreement (hereinafter referred to as "PBM agreement") with a PBM for the provision and administration of pharmacy services, the agreement shall be developed as a pass-through pricing model

as defined below. For the purposes of this Agreement, all requirements applicable to a PBM shall also apply to any contract or agreement the MCP has with a Pharmacy Benefit Administrator (PBA).

a. For the purposes of this Agreement, a pass-through pricing model is defined as a PBM agreement type where:

    i. All monies related to services provided for the MCP are passed through to the MCP, including but not limited to: dispensing fees and ingredient costs paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, rebates[2], inflationary payments[3], and supplemental rebates;

    ii. All payment streams, including any financial benefits such as rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other payments that the PBM receives related to services provided for the MCP are fully disclosed to the MCP, and provided to ODM upon request; and

    iii. The PBM is paid an administrative fee which covers their cost of providing the PBM services as described in the PBM contract as well as margin.

b. The payment model for the PBM's administrative fee shall be made available to ODM. If concerns are identified, ODM reserves the right to request any changes be made to the payment model.

c. The PBM agreement shall allow for the MCP to perform a competitive market check at least every three years or allow the MCP to annually renegotiate its terms.

d. The MCP shall work with ODM throughout calendar year 2020 to establish a value-based payment model to be effective on a date established by ODM.

e. **PBM Agreement Language**.

    i. The following provisions shall be included in any agreement between the MCP and their PBM:

        c. At least annually, the PBM shall hire an independent third party to complete a Service Organization Controls report (SOC-1) audit over the PBM's services and activities. This report shall be provided to the MCP, and information from this audit shall be made available to ODM upon request.

        d. In addition to the SOC-1 audits, the PBM and the MCP shall cooperate with and grant full access to any independent audit entity retained by or otherwise operating on behalf of ODM to perform periodic compliance audits of each PBM. These compliance audits would measure the PBMs' compliance with any

[2] Rebates include manufacturer fees and administration fees for rebating.
[3] Inflationary payments refers to any agreement a PBM may have with a manufacturer where the manufacturer agrees to a payment back to the PBM if a drug has inflation above an agreed upon level.

contractual obligations as well as with federal and state requirements. The PBMs shall correct any noncompliance issues discovered during these audits.

e. The PBM shall not steer or require any providers or members to use a specific pharmacy in which the PBM has an ownership interest or that has an ownership interest in the PBM, if for the primary purpose of reducing competition or financially benefitting the PBM's associated businesses. Arrangements between MCPs and PBMs to promote value-based reimbursement and purchasing or enhancing health outcomes are permitted.

f. The PBM shall load eligibility information into their system within 24 hours of receipt of the 834C file from the MCP.

g. The PBM shall report semi-annually to the MCP their list of specialty drugs by National Drug Code, including a report on any drugs that have moved between specialty and non-specialty designation.

h. The PBM shall submit a report containing data from the prior calendar year to the MCP. The report shall be made available to ODM upon request and contain the following information:

    a. The aggregate amount of all rebates that the PBM negotiated from all pharmaceutical manufacturers on behalf of the MCP; and

    b. The aggregate administrative fees that the PBM negotiated from all pharmaceutical manufacturers on behalf of the MCP.

ii. The following provisions shall be addressed in any agreement between the MCP and their PBM:

1. The ability for the MCP, or its designee that has no ownership or control interest with the PBM, to audit and review contracts or agreements between the PBM and their pharmacies at least annually to ensure correct pricing has been applied. This includes, but is not limited to, prescription drug claim data, billing records, and other records to ensure the PBM's compliance with the terms and conditions of their agreement.

2. If there is not a provision in the agreement to restrict the PBM from selling pharmacy data, the MCP shall require a secure process to be included and followed. If any Ohio Medicaid MCP pharmacy data is sold, aggregate total amount received by the PBM for the MCP's data shall be reported to the MCP at least semi-annually.

3. The ability for the MCP, at its discretion, to enter into non-exclusive specialty pharmacy network arrangements when a specialty pharmacy can provide a better price on a drug.

4. A clause that allows the MCP to terminate the agreement for cause, including conduct that is likely to mislead, deceive, or defraud the public, as well as unfair or deceptive business practices.

5. A clause that grants ODM access to financial terms and arrangements that PBMs have with pharmaceutical drug manufacturers and distributors. Reasonable confidentiality provisions can be included to protect this information if it is deemed a trade secret, subject to compliance with all laws and orders of courts and powers of investigative agencies, to protect against public disclosure.

f. Upon request, the MCP shall disclose to ODM all financial terms and arrangements for payment of any kind that apply between the MCP, or the MCP's FDR, and any pharmaceutical drug manufacturers or distributors, except where federal and state law restricts disclosing the terms and arrangements. This disclosure shall include financial terms and payment arrangements for formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and all other fees. ODM acknowledges that such information may be considered confidential and proprietary and thus shall be held confidential by ODM as specified in Article VII of this Agreement.

g. **Single State PBM.** In accordance with ORC 5167.241, the MCP shall use, as specified by ODM, the state PBM selected by ODM under ORC 5167.24 for the processing of all pharmacy claims and shall cooperate with ODM during the implementation of the state PBM.

7. **Pharmacy Tiered Dispensing Fee**. Pursuant to ORC 333.280, the MCP shall provide a tiered dispensing fee to retail pharmacies as specified by ODM. The tiered dispensing fee shall not cause a reduction in other payments made to the pharmacy for providing prescribed drugs.

8. **Prescribed Drug Claims Processing Pilot Program**. Pursuant to ORC 333.290, the MCP shall participate in a pilot program for the pre-audit processing of prescribed drug claims submitted to the MCP or their PBM through December 31, 2020 as specified by ODM.

9. **NDC Drug List.** The MCP shall maintain an updated weekly NDC drug list showing all items covered on the MCP's Drug File.

The sanctions for noncompliance with requirements in this appendix are listed in Appendix N of this Agreement.

APPENDIX S

STATE OF EMERGENCY REQUIREMENTS

During the state of emergency declared due to the COVID-19 pandemic, ODM will be taking measures to reduce barriers to access to care, keep individuals healthy in the community to reduce hospital admissions, and to reduce administrative burden on hospitals and providers. Unless otherwise described in this Appendix, and effective immediately upon signature from both the MCP and the ODM Director, the MCP shall implement the following until a time when directed by ODM in writing to cease the requirements. ODM and the MCP will remain flexible during this pandemic, and the MCP will implement any future requirements not outlined in this Appendix as directed by ODM.

1. The MCP shall honor any previously approved prior authorization for a treatment, procedure, or service for up to six months when the treatment, procedures, or services have been postponed between January 1, 2020 and June 30, 2020.

2. ODM recognizes the need for fraud, waste, and abuse prevention, however, the current priority is the safety and welfare of Medicaid members. ODM expects the MCP to continue monitoring utilization and conducting retrospective reviews.

3. The MCP shall not impose any member cost-sharing for state plan services during the time that this appendix is enacted. Patient liability remains a requirement for long-term services and supports (LTSS), which includes both waiver services and nursing facility care.

4. **COVID-19 Testing and Treatment.**

    a. Effective February 4, 2020, the MCP shall cover all COVID-19 testing and pay at least 100% of the Medicare rate as established in the "ODM Clinical Diagnostic and Pathology Procedures" fee schedule with no restrictions or cost sharing.

    b. Testing codes for COVID-19 include any newly developed test in addition to the following:

        i. U0001 – CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel - CMS developed the first Healthcare Common Procedure Coding System (HCPCS) code (U0001) last month to bill for tests and track new cases of the coronavirus. This code is used specifically for Centers for Disease Control and Prevention (CDC) testing laboratories to test patients for SARS-CoV-2.

        ii. U0002 - non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19) – This code allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects use of these specific codes for these tests will encourage testing and improve tracking.

    c. The MCP shall cover treatment and vaccinations for COVID-19 without restrictions or cost sharing.

5. **Pharmacy Requirements.** The MCP shall:

    a. Relax all refill thresholds in the pharmacy benefit to 50% until further notice. This includes both controlled and non-controlled substances.

    b. Waive all copayments or cost sharing in the pharmacy benefit until further notice.

    c. Ensure any pharmacist who dispenses an emergency refill of a medication without a prescription in accordance with ORC section 4729.281 is reimbursed.

    d. Allow acute opioids prescriptions to be filled for up to 14 days to allow adequate supply for individuals that may be quarantined. In accordance with OAC rule 4731-11-13, the seven-day limit for adults and five-day limit for minors may be exceeded for pain that is expected to persist for longer than seven days based on the pathology causing the pain. In this circumstance, the reason that the limit is being exceeded, and the reason that a non-opioid medication was not appropriate to treat the patient's conditions, shall be documented in the patient's medical record.

    e. At a minimum, continue to allow a 90-day supply of medication using the list of medications that the MCP currently uses to allow a 90-day supply.

    f. Remove all barriers that may exist for home or mail delivery services, as well as diabetic testing supplies and respiratory aerosol machines, in the pharmacy benefit.

    g. Have a process to allow an override for non-MCP network pharmacies to submit and get paid for a pharmacy claim until the state of emergency declared by the Governor of the State of Ohio has been lifted or as determined by the ODM Director. ODM will not dictate this process. The MCP shall have a process to allow an override for an unenrolled prescriber to write a prescription for a member.

    h. Allow non-participating pharmacy providers to submit claims at the same/similar rates used for participating pharmacy providers and shall apply all the conditions, restrictions, and allowances outlined in this Appendix to non-participating pharmacy providers.

    i. Waive the requirement for signatures for prescriptions pick-up.

    j. Not conduct any audits that would be overly burdensome to pharmacies.

    k. Permit and provide coverage for pharmacy compounding in accordance with the Automatic Exemptions to ORC 4729-16-10 and Expanded Definitions of Drug Shortages released by the Ohio Board of Pharmacy.

    l. Not make any changes to their current drug coverage that is more restrictive than the effective date of this Appendix.

6. **Telehealth.** At a minimum, the MCP shall follow OAC rule 5160-1-18 "Telemedicine", including any emergency rule versions of OAC rule 5160-1-18, and any future telehealth rules or services developed during the time that this appendix is enacted, including OAC rule 5160-1-21, but may be less restrictive if appropriate. OAC rule 5160-1-21 is effective beginning on the date Governor DeWine declared a state of emergency: March 9, 2020.

7. **Timely Filing of Claims.** The MCP shall accept claims from all provider types for up to 365 calendar days from the date of service.

8. **Social Distancing.**

    a. The MCP shall implement social distancing to the extent possible. This includes MCP staffing as well as contact with MCP members. Meetings such as the Member Advisory Committee Meetings may be held by phone or webinar and not in person.

    b. All face-to-face interactions with members shall be completed through telephone or through other electronic communication.

9. **Reporting Requirements.** In addition to any incident management system requirements already in place, the MCP shall provide the following information to ODM using a format and process prescribed by ODM:

    a. Submit documentation to ODM on the payment of clean claims by provider type for the past three months, and then on a weekly basis until further notice, using a format and process prescribed by ODM.

    b. As specified by ODM, provide COVID-19 related reports upon request.

    c. Report the implementation status of the requirements of this appendix using the process and format prescribed by ODM.

    d. Submit to ODM any reported drug shortages and participate in any efforts to identify drug shortages as directed by ODM.

    e. Notify ODM of any potential provider shortages (e.g. home health, behavioral health, oxygen, etc.) when the MCP becomes aware of the issue.

10. **Communicating with Members and Providers.** The MCP shall develop a communication protocol for when a member tests positive for COVID-19 to provide notification to the member's providers.

11. **Care Management and Backup Planning.**

    a. The MCP shall follow guidance provided in the "Emergency Protocol" developed initially on March 13, 2020, in collaboration with ODM. This document will be updated periodically. ODM will reissue the document as needed.

b. The MCP shall review backup plans for higher risk individuals. If a backup plan is not feasible, the MCP must assist in developing and adjusting the backup plan as needed.

12. **Health Care Isolation Center (HCIC) Requirements.** Under the guidance of the Ohio Department of Health (ODH), HCICs will be established throughout the state that specialize in the care of patients with active or convalescent COVID-19 infection or who have other health care needs and require quarantine for up to 14 calendar days following exposure to COVID-19.

    a. **HCIC Prior Authorization and Levels of Care.** The MCP is prohibited from imposing prior authorization on an HCIC stay. An individual's treating physician will determine if HCIC admission is appropriate by determining if the individual has an appropriate HCIC level of care as outlined below.

        i. **COVID-19 Level of Care.** A COVID-19 level of care requires a level of care comparable to that required for admission to a nursing facility, a COVID-19 diagnosis (tested or probable), and a physician order.

        ii. **Quarantine Level of Care.** A quarantine level of care requires a level of care comparable to that required for admission to a nursing facility, exposure to COVID-19 which requires quarantine, and a physician order.

    b. **Managed Care Enrollment.** Members not receiving Medicaid in the Adult Extension category will not be terminated from managed care enrollment in accordance with OAC rule 5160-26-02.1 due to HCIC placement. The MCP shall not request disenrollment of members not receiving Medicaid in the Adult Extension category due to prolonged HCIC placement.

    c. **Rates and Reimbursement.** The Medicaid Director will designate HCICs who meet an identified need within a Regional Hospital Zone as a COVID-19 Community Provider as authorized by Section 14 of Am. Sub. H.B. 197 as passed by the 133rd General Assembly. The MCP shall pay HCICs that have been designated as a COVID-19 Community Provider using a tiered flat per diem rate system as specified by ODM. Patient liability applies to COVID-19 Community Provider payments and shall be deducted from claims using current processes.

    d. **Discharge Planning.** The HCIC and the treating physician will be responsible for deciding if discharge from the HCIC is appropriate in accordance with guidelines issued by the Ohio Department of Health. Individuals may be discharged to home settings or congregate settings, such as nursing facilities. If the individuals were receiving services in a NF when they became ill with COVID-19 or needed to be quarantined with COVID-19, in most cases they should return to the same NF. The MCP shall participate in discharge planning activities with the HCIC including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCP.