Citation		Condition or Requirement
1932(a)(1)(A)	A.	Section 1932(a)(1)(A) of the Social Security Act. The State of __Ohio_____ enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d). Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)-(2)	B.	Managed Care Delivery System. The State will contract with the entity(ies) below and reimburse them as noted under each entity type. 1. ☒MCO a. ☒Capitation 2. ☐PCCM (individual practitioners) a. ☐ Case management fee b. ☐ Bonus/incentive payments c. ☐ Other (please explain below) 3. ☐PCCM (entity based) a. ☐ Case management fee b. ☐ Bonus/incentive payments c. ☐ Other (please explain below) For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the

Citation	Condition or Requirement

following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

☐b. Incentives will be based upon a fixed period of time.

☐c. Incentives will not be renewed automatically.

☐d. Incentives will be made available to both public and private PCCMs.

☐e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

The State engaged key stakeholders in its initial implementation and design of the program and continues to engage them through community-based meetings and forums as well as regular, ongoing meetings to assure ongoing public involvement in Ohio's managed care system. These key stakeholders include: providers, consumer advocates, MCOs, county departments of job and family services, local health departments and other social service agencies. The statewide Medical Care Advisory Committee serves as a forum for discussion of the managed care program and related issues.

In addition to ongoing group meetings, ODM convenes ad hoc "roundtables" to discuss specific issues such as the addition of new populations to managed care, additions or changes to covered services, and care management, access to services, and implementation of new federal initiatives and regulations.

Citation	Condition or Requirement

D. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1.	☒The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2.	☐The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	☒The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring Beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4.	☒The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5.	☒The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6.	☒The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7.	☒The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) CFR 447.362 42 CFR 438.50(c)(6)	8.	☐The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.
45 CFR 92.36	9.	☒The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Citation	Condition or Requirement

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
Section 1931 Adults & Related Populations1905(a)(ii)	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
Low-Income Adult Group	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
Former Foster Care Children under age 21	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
Former Foster Care Children age 21-25	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
Section 1925 Transitional Medicaid age 21 and older	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
Poverty Level Pregnant Women – 1905(a)(viii)	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
SSI and SSI related Disabled children under age 18	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD

Citation Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)	M	Statewide			Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					
Recipients Eligible for Medicare					
American Indian/Alaskan Natives			V	Statewide	
Children under 19 who are eligible for SSI					
Children under 19 who are eligible under Section 1902(e)(3)	N/A	Ohio did not take the option under 1902(e)(3) for the Katie Beckett waiver or TEFRA			
Children under 19 in foster care or other out-of-home placement					Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)					Institutionalized Enrolled in HCBS Waiver, except individuals receiving 1915(c) HCBS waiver services through the Ohio DODD
Other Title XXI CHIP Children	M	Statewide			
Adult Group 19-64 eligible under 42 CFR 435.119 [1902(a)(10)(A)(i)(viii)]	M	Statewide			
Recipients receiving HCBS 1915(c) waiver services through the Ohio Department of Developmental Disabilities			V	Statewide	

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care

Citation	Condition or Requirement

program. Please indicate if any of the following groups are excluded from participating in the program:

☐Other Insurance--Medicaid beneficiaries who have other health insurance.

☐Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

☐Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☒ Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☒ Other (Please define):
- Institutional individuals in intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
- Individuals enrolled in the program of all-inclusive care for the elderly (PACE)

1932(a)(4) F. Enrollment Process.

1. Definitions.

   a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

   b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. ☐ The applicant is permitted to select a health plan at the time of application.

Citation | Condition or Requirement

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. What action the state takes if the applicant does not indicate a plan selection on the application.

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence*.)

b. ☐ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment.

c. ☒ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e). The enrollment notice explains the managed care program, the population(s) required to enroll in an MCO, the exempt populations, contact information including the enrollment broker's toll free phone number, website, available MCOs, and the ability to switch managed care plans within the first 90 days of enrollment in the plan.

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence*.) The individual is sent a notice with the managed care plan information on it. The enrollment notice explains the managed care program, the population(s) required to enroll in

Citation	Condition or Requirement

an MCO, the exempt populations, contact information including the enrollment broker's toll free phone number, website, available MCOs, and the ability to switch managed care plans within the first 90 days of enrollment in the plan.

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f). The auto-assignment algorithm is a hierarchy of multiple steps with the goal of assigning individuals to the managed care plan that best matches their needs and preserves the existing provider-patient relationships, including relationships that may exist for persons with special health care needs. If an individual has been enrolled in an MCO in the previous six months, he or she is enrolled into the same MCO. If an individual has a family member in the same Medicaid case that is currently enrolled, the individual is enrolled in the same MCO as the rest of his or her family. For individuals who do not have an enrollment history, an assignment will be created based on the Medicaid fee-for-service providers the member has utilized in the last 12 months, matched to each of the MCOs' provider networks, if prior utilization exists. If the Medicaid recipient does not have an existing relationship with a Medicaid fee-for-service provider, the managed care assignment is based on quarterly quality assessments of the MCO in five key health-related performance standards. ODM weights the percentages of assignments to each individual MCO based on the results of the quality assessments. Assignments are also based on the MCO's member enrollment and provider network capacity in each county. If an MCO's ratio of member enrollment to provider network capacity is too high in a particular county, assignments will be blocked for that MCO in that county for the entire month. Enrollees have up to 90 days from enrollment to change MCO without cause, and, after that, annually during open enrollment.

1932(a)(4)
42 CFR 438.50

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

a. ☒The state assures it has an enrollment system that allows Beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

Citation	Condition or Requirement

b. ☒The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

c. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

☒This provision is not applicable to this 1932 State Plan Amendment.

d. ☒ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☐This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will☒/will not☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for twelve months (up to 12 months).

3. ☒The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The State's enrollment broker provides written notification in the initial enrollment notice advising consumers of their right to disenroll without cause during the first 90 days of enrollment. In addition, this information is also included in the MCO member handbook and in the open enrollment notice.

5. Describe any additional circumstances of "cause" for disenrollment (if any).

In addition to the circumstances for disenrollment with "cause" permitted in accordance with 42 CFR 438.56(d)(2), the State added the following circumstances for disenrollment with "cause" in Ohio Administrative Code. The circumstances are:

Citation	Condition or Requirement

1. The member moves out of the MCO's service area and a non-emergency service must be provided out of the service area before the effective date of the member's automatic termination.
2. The primary care provider (PCP) selected by a member leaves the MCO's panel and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the language is available and accessible in another MCO in the member's service area.
3. A situation in which, as determined by the State, continued membership in the MCO would be harmful to the interests of the member.

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒The state assures that its state plan program is in compliance with 42 CFR 438.10(e) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.
Each MCO is responsible for covering the Medicaid benefits described in the Ohio Managed Care provider agreements which CMS approves.

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☒The state assures that each managed care organization has established an internal grievance procedure for enrollees.

1932(a)(5)(D)(b)(5)
42 CFR 438.206
42 CFR 438.207

K. Describe how the state has assured adequate capacity and services.

The State contractually requires the MCOs to provide each beneficiary access to all Medicaid covered medically necessary services. In order to assure adequate capacity and availability of services, the State has established provider panel minimum standards in the State's Managed Care Provider Agreement. Each MCO must contract with a minimum number of providers to meet this standard which provides evidence that the MCO has an adequate provider panel capacity to meet the need of its members. These provider panel requirements are defined down to the county level to assure provider capacity is available in all parts of the State. The State runs regular reports on each MCO's provider panel and assesses compliance quarterly if an MCO does not meet these minimum standards. In addition, to the provider panel requirements, the State monitors each MCO's grievances and appeals along with provider and consumer complaints. This information is reviewed at least monthly and assists in identifying any consumer issues with access to providers.

Citation		Condition or Requirement
1932(a)(5)(D)(c)(1)(A) 42 CFR 438.240	L.	☒The state assures that a quality assessment and improvement strategy has been developed and implemented.
1932(a)(5)(D)(c)(2)(A) 42 CFR 438.350	M.	☒The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.
1932 (a)(1)(A)(ii)	N.	Selective Contracting Under a 1932 State Plan Option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will☒/will not☐ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. ☒The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* The State uses a competitive application process designed to select a limited number of MCOs. The selection is based on criteria that take into account each MCO's experience, capacity and quality. 4. ☐The selective contracting provision in not applicable to this state plan.