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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 ~~voluntary~~ 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 (but enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)
	B. General Description of the Program and Public Process. For B.1 and B.2, place a check mark on any or all that apply.
1932 (a)(1)(B)(i) 1932 (a)(1)(B)(ii) 42 CFR 438.50 (b)(1)	1. The State will contract with an ___ i. MCO X ii. PCCM (including capitated PCCMs that qualify as PAHPs) ___ iii. Both
42 CFR 438.50 (b)(2) 42 CFR 438.50 (b)(3)	2. The payment method to the contracting entity will be: ___ i. fee for service; X ii. capitation; ___ iii. a case management fee; ___ iv. a bonus/incentive payment; ___ v. a supplemental payment. X vi. other, risk corridor payment arrangement
1905 (t) 42 CFR 440.168	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. Place a check mark to affirm the following conditions are met. ___ i. 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.

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	____ii. Incentives will be based upon specific activities and targets.
	____iii. Incentives will be based upon a fixed period of time.
	____iv. Incentives will not be renewed automatically.
	____v. Incentives will be made available to both public and private PCCMs.
	____vi. Incentives will not be conditioned on intergovernmental transfer agreements.
CFR 438.50 (b)(4)	4. Describe the public process 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 Ohio Medicaid managed care program has consistently sought to involve interested parties in development and operational activities. During the design and development phase of the enhanced care management (ECM) program, public forums were held with a number of key stakeholders, including but not limited to: providers and provider associations, consumer advocates, county agencies, and other state agencies, such as the Department of Health, Bureau of Children with Medical Handicaps, which administers the state's Title V program. Information about the ECM program, including the request for applications (RFA) and questions and answers about the RFA have been posted at Ohio Medicaid's web site. The web site will continue to be updated as relevant information becomes available. Finally, the state's Medical Care Advisory Committee (MCAC) has also served as a forum for discussion of the ECM program. As the ECM program enters its implementation phase, Ohio Medicaid will continue to seek input through public meetings and the MCAC.*~~
1932 (a)(1)(A)	5. The state plan program will___/will not _X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ~~voluntary~~ enrollment will be implemented in the following county/area(s):
	i. county/counties ~~*Cuyahoga, Franklin, Hamilton, Lucas, Montgomery, Stark, Summit, and Zanesville Service Area which consists of Muskingum, Coshocton, Guernsey, Morgan, Noble, and Perry Counties.*~~
	ii. area/areas _____
	C. State Assurances and Compliance with the Statute and Regulations.

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	Place a check mark to affirm state assurance that compliance with the following statutes and regulations have been 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. X The state assures that all the applicable requirements of section 1905 (t) of the Act ~~and applicable PAHP requirements in 42 CFR 438~~ for PCCMs and PCCM contracts will be met.
1932 (a)(1)(A) 42 CFR 438.50 (c)(3)	3. X 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 recipients to receive their benefits through managed care entities will be met.
1932 (a)(1)(A 42 CFR 431.51 1905 (a)(4)(C)	4. X 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) 42 CFR 438 42 CFR 438.50 (c)(4) 1903 (m)	5. X The state assures that all applicable requirements of 42 CFR 438 for MCOs and PCCMs will be met.
1932 (a)(1)(A) 42 CFR 438.6 (c) 42 CFR 438.50 (c)(6)	6. X 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) 42 CFR 447.362 42 CFR 438.50 (c)(6)	7. ____ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. X The state assures that all applicable requirements of 45 CFR ~~74.40~~ 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932 (a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis.
	2. Mandatory exempt groups

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	Use a check mark to indicate if the state will enroll any of the mandatory exempt groups on a voluntary basis.
1932 (a)(2)(B) 42 CFR 438 (d)(1)	i. Recipients who are also eligible for Medicare ~~X~~ The state will allow these individuals to voluntarily enroll in the managed care program. ~~*ABD consumers who are Medicare eligible are not eligible for the ECM program. However, if an ECM member becomes Medicare-eligible after enrollment into the ECM program, they may continue to stay in the ECM program or they may disenroll. (All ECM members have the option to end their membership each month).*~~
1932 (a)(2)(C) 42 CFR 438 (d)(2)	ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. ____The state will allow these individuals to voluntarily enroll in the managed care program.
1932 (a)(2)(A)(i) 42 CFR 438.50 (d)(3)(i)	iii. Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI. ~~X~~ The state will allow these individuals to voluntarily enroll in the managed care program.
1932 (a)(2)(A)(iii) 42 CFR 438.50 (d)(3)(ii)	iv. Children under the age of 19 years who are eligible under 1902(e)(3) of the Act. ___The state will allow these individuals to voluntarily enroll in the managed care program. ~~*These individuals will not be allowed to voluntarily enroll into the ECM program*~~.
1932 (a)(2)(A)(v) 42 CFR 438.50 (3)(iii)	v. Children under the age of 19 years who are in foster care or other out-of-the-home placement. ____The state will allow these individuals to voluntarily enroll in the managed care program.

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	~~*These individuals will not be allowed to voluntarily enroll into the ECM program*~~.
1932 (a)(2)(A)(iv) 42 CFR 438.50 (3)(iv)	vi. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. ____ The state will allow these individuals to voluntarily enroll in the managed care program. ~~*These individuals will not be allowed to voluntarily enroll into the ECM program.*~~
1932 (a)(2)(A)(ii) 42 CFR 438.50 (3)(v)	vii. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. _X_ The state will allow these individuals to voluntarily enroll in the managed care program.
	E. Identification of Mandatory Exempt Groups
1932 (a)(2) 42 CFR 438.50 (d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* ~~*These are children served through the Ohio Department of Health, Bureau of Children with Medical Handicaps (BCMH). BCMH administers Ohio's Title V program.*~~
1932 (a)(2) 42 CFR 438.50 (d)	2. The state's definition of these children is determined by: _X_ i. program participation ____ ii. special health care needs.
1932 (a)(2) 42 CFR 438.50 (d)	3. The scope of these title V services include services received through a family-centered, community-based, coordinated care system. _X_ i. yes ____ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

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	i. Children under 19 years of age who are eligible for SSI under title XVI; ~~*Enrollment in the ECM program is voluntary for all ECM eligibles. Ohio Medicaid will rely on self-identification to identify children under 19 years of age who are eligible for SSI.*~~
	ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;
	iii. Children under 19 years of age who are in foster care or other out-of-home placement;
	iv. Children under 19 years of age who are receiving foster care or adoption assistance.
1932(a)(2) 42 CFR 438.50 (d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*
1932 (a)(2) 42 CFR 438.50 (d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*
	i. Recipients who are also eligible for Medicare. ~~*Recipients who are also eligible for Medicare will be identified based on their eligibility category.*~~
	ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment
42 CFR 438.50	G. List all other eligible groups that will be permitted to enroll on a voluntary basis ~~*The ECM program will initially target all of the following populations and clinical conditions:*~~

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	~~• Adult ABD consumers with a diagnosis of congestive heart failure (CHF), coronary arterial disease (CAD), or hypertension; diabetes; chronic obstructive pulmonary disease (COPD); or asthma;~~ ~~• ABD consumers under the age 21 with asthma.~~ ~~All Medicaid ABD consumers in the above groups will be considered eligible for the ECM program, except for those:~~ ~~• Residing in nursing facilities (NFs) or intermediate care facilities for the mentally retarded (ICFs-MR);~~ ~~• Enrolled in Medicaid home and community based waiver programs;~~ ~~• Receiving services related to transplants, AIDS, cancer, end stage renal disease (ESRD), severe trauma, and hospice, or~~ ~~• Medicare eligible~~ ~~An ECM member who, during the time of ECM membership, enters NFs for short-term stays will not be disenrolled except at the members request. An ECM member who begins receiving treatment for transplants, cancer, ESRD, AIDS, or severe trauma, or who becomes Medicare-eligible, will only be disenrolled from the ECM program at the member's request.~~
	H. Enrollment process. ~~Section H does not apply to Ohio's ECM program due to the fact that enrollment is voluntary. Medicaid consumers identified as ECM eligible will be notified by the state. Membership in the ECM program will be automatic unless the consumer calls the state's designated toll-free number to indicate that they do not wish to be an ECM member. ECM members will not be required to remain in the ECM program and will have the option to end their membership at the end of each month.~~
1932 (a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932 (a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve:

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	i. the existing provider-recipient relationship (as defined in H.1.i).
	ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).
	iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702 (a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*
1932 (a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:
	i. The state will___/will not __ use a lock-in for managed care managed care.
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be_____.
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*
	iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*
	v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*
	vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*
1932 (a)(4) 42 CFR 438.50	I. State assurances on the enrollment process
	Place a check mark to affirm that the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.
	1. X The state assures it has an enrollment system that allows recipients 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

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	program.
	2. ____The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients 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).
	3. ____The state plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs.
	_X_ This provision is not applicable to this 1932 State Plan Amendment.
	4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932 (a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)
	___ This provision is not applicable to this 1932 State Plan Amendment.
	5. _X_ 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 438.50	J. Disenrollment
	1. The state will___/will not _X_ use lock-in for managed care.
	2. The lock-in will apply for ____ 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). (Place a check mark to affirm state compliance.)
	~~*Not applicable – The state does not restrict disenrollment as enrollment is voluntary and beneficiaries may disenroll at any time*~~.
	4. Describe any additional circumstances of "cause" for disenrollment (if any).
	K. Information requirements for beneficiaries
1932 (a)(5) 42 CFR 438.50	_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10 (i) for information requirements specific to MCOs and PCCM programs

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42 CFR 438.10		operated under section 1932 (a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932 (a)(5)(D) 1905 (t)	L.	List all services that are excluded ~~included~~ for each model (MCO & PCCM) ~~*Enhanced Care Management Services*~~
	M.	Describe how the number of contractors per service area will be limited ~~*It is not likely that the number of ECM eligibles in most service areas will be sufficient to warrant more than one ECM plan per service area. (The average number of ECM eligibles per service area ranges from approximately 2,000 to 10,000 individuals). It is possible that in the largest service areas where there is a larger number of ECM eligibles, that ODJFS could enter into an agreement with more than one ECM plan.*~~

~~*April 2, 2004*~~