Contract

Between

United States Department of Health and Human Services
Centers for Medicare & Medicaid Services

In Partnership with

The State of Ohio

Department of Medicaid

and

_____

Issued:

February 11, 2014

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This Contract, made on _____, 2014, is between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the State of Ohio, acting by and through the State of Ohio Department of Medicaid (ODM) and _____ (the ICDS Plan). The ICDS Plan's principal place of business is _____.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and Ohio Children's Health Insurance Programs under Title XVIII, Title IX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, the Ohio Department of Medicaid (ODM) is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and Title 51 of the Ohio Revised Code, designed to pay for medical services for eligible individuals;

WHEREAS, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures under Titles XVIII and XIX of the Social Security Act while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

WHEREAS, the ICDS Plan is in the business of providing coverage for medical services, and CMS and ODM desire to purchase such services from the ICDS Plan;

WHEREAS, the ICDS Plan agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and Ohio laws and regulations;

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

Section 1. Definition of Terms

1.1 Action — Also, "Adverse Action", the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner, as defined by the State; failure of a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) to act within the timeframes; or, for a rural area resident with only one MCO or PIHP, the denial of a Medicaid Beneficiary's request to obtain services outside the network.

1.2 Appeal — A request for formal review of an Adverse Action of the ICDS Plan in accordance with Section 2.12 of the Contract.

1.3 Applicable law—as used in this Contract means, without limitation, all federal and Ohio law and regulations, and the regulations, policies, procedures, and instructions of CMS and ODM all as existing now or during the term of this Contract.

1.4 Beneficiary(ies) — Any Medicare-Medicaid eligible individual who is eligible for the demonstration and enrolled with an ICDS Plan for both Medicaid and Medicare benefits.

1.5 Beneficiary Communications — Materials designed to communicate to Beneficiaries plan benefits, policies, processes and/or Beneficiary rights. This includes pre-enrollment, post-enrollment, and operational materials.

1.6 Business Days —Monday through Friday, except for federal and state holidays.

1.7 Capitated Financial Alignment Model ("the Demonstration") — A model where Ohio, CMS, and a health plan enter into a three-way contract, and the plan receives prospective payments to provide comprehensive, coordinated care.

1.8 Capitation Rate — The sum of the monthly capitation payments (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract) including: 1) the application of any risk adjustment methodologies, as described in Section 4; and 2) any payment adjustments as a result of the reconciliation described in Section 4. Total Capitation Rate Revenue will be calculated as if all ICDS Plans had received the full quality withhold payment.

1.9 Care Manager — An appropriately qualified professional who is the ICDS Plan's designated accountable point of contact for each Beneficiary receiving care management services. The Care Manager is responsible for directing and delegating care management duties, as needed, and may include the following: facilitating assessment of needs; developing, implementing and monitoring the care plan; and serving as the lead of the trans-Disciplinary care management team.

1.10 Care Management — A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and

Medicaid) required to meet a Beneficiary's needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost effective, positive outcomes.

1.11 Centers for Medicare & Medicaid Services (CMS) — The federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

1.12 Claim — (1) a bill for services; (2) a line item of services; or (3) all services for one recipient within a bill.

1.13 Clean Claim — A Claim that can be processed without obtaining additional information from the Provider of a service or from a third party.

1.14 Comprehensive Assessment — The process for review and assessment of medical, behavioral health, LTSS and social needs for Beneficiaries enrolled in the ICDS Plan in order to develop a person centered individualized care plan.

1.15 Consumer Assessment of Healthcare Providers and Systems (CAHPS) — Beneficiary survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care.

1.16 Contract — The participation agreement that CMS and ODM have with an ICDS Plan, for the terms and conditions pursuant to which an ICDS Plan may participate in this Demonstration.

1.17 Contract Compliance Officer — The designated individual that is employed by the ICDS Plan that is responsible primarily for monitoring the compliance activities under the Demonstration and reports to senior leadership within the ICDS Plan. The individual also acts as the liaison between the ICDS Plan and ODM and CMS.

1.18 Contract Management Team (CMT) — A group of CMS and ODM representatives responsible for overseeing the contract management functions outlined in Section 3.1 of the Contract.

1.19 Contract Operational Start Date — The first date on which any Enrollment into the ICDS Plan's is effective.

1.20 Covered Services — The set of services to be offered by the ICDS Plans. Refer to Appendix A.

1.21 Coverage Determination — An ICDS Plan decision to approve or deny a request for a covered service, also referred to as Prior Authorization decision.

1.22 Cultural Competence — Understanding those values, beliefs, and needs that are associated with an individual's age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

1.23 Demonstration — The program, MyCare Ohio, administered by CMS and the Ohio Department of Medicaid (ODM) for providing integrated care to Medicare-Medicaid Beneficiaries that is the subject of this Contract.

1.24 Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

1.25 Emergency Services — Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R Part 438 and that are needed to evaluate or stabilize an emergency medical condition.

1.26 Encounter — An individual service or procedure provided to a Beneficiary that would result in a claim if the service or procedure were to be reimbursed as Fee-For-Service under the ODM Medical Program.

1.27 Encounter Data — The record of a Beneficiary receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS and ODM. This record must incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.

1.28 Enrollment — The processes by which an individual who is eligible for the Demonstration is enrolled in an ICDS Plan.

1.29 External Quality Review Organization (EQRO) — An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by managed care organizations to their Medicaid Beneficiaries.

1.30 Federally-Qualified Health Center (FQHC) — An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(1)(2)(B).

1.31 First Tier, Downstream and Related Entity — An individual or entity that enters into a written arrangement with the ICDS Plan acceptable to CMS and ODM, to provide administrative or health care services of the ICDS Plan under this Contract. Specifically,

First Tier Entity means any party that enters into an acceptable written arrangement with an ICDS Plan to provide administrative services or health care services for a MyCare Ohio Beneficiary. Downstream Entity means any party that enters into an acceptable written arrangement below the level of arrangement between an ICDS Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Related Entity means any entity that is related to the ICDS Plan by common ownership or control and 1) performs some of the ICDS Plan's management functions under contract or delegation; 2) furnishes services to MyCare Ohio Beneficiaries under an oral or written agreement; or 3) leases real property or sells materials to the ICDS Plan at a cost of more than $2,500 during the Contract period.

1.32 Fraud — Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

1.33 Grievance — An expression of dissatisfaction about any matter other than an action; includes grievances. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Beneficiary's rights.

1.34 Health Disparities – as defined by the U.S. Department of Health and Human Services – Centers for Disease Control and Prevention, differences in health outcomes and their determinants as defined by social, demographic, geographic, and environmental attributes.

1.35 Health Home —Health home service for persons with serious and persistent mental illness is a person-centered holistic approach that provides integrated behavioral health and physical health care coordination and care management for individuals with serious and persistent mental illness.

1.36 Health Insuring Corporation (HIC) —A corporation licensed by the state that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

1.37 Health Outcomes Survey (HOS) — Beneficiary survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

1.38 Health Plan Management System (HPMS) — A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

1.39 Healthcare Effectiveness Data and Information Set (HEDIS) — Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

1.40 Home and Community-Based Services (HCBS) Waivers — Waivers under Section 1915(c) of the Social Security Act that allow the State to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the Level of Care (LOC) provided in an institution but who, with special services, may remain in their homes and communities.

1.41 Individualized Care Plan (ICP) — An integrated, individualized, person-centered care plan developed by the Beneficiary and his or her ICDS Plan's Trans-Disciplinary Team that addresses clinical and non-clinical needs identified in the comprehensive assessment and includes goals, interventions and expected outcomes.

1.42 Integrated Care Delivery System Plan ("ICDS Plan" or "ICDS Plans") — A Managed Care Organization that enters into a Three-Way Contract with CMS and ODM to provide Covered Services and any chosen flexible benefits and be accountable for providing integrated care to Medicare-Medicaid Beneficiaries. The plan must comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Beneficiaries including long term services and supports.

1.43 Long Term Services and Supports (LTSS) — A range of home and community services and supports designed to meet a Beneficiary's needs as an alternative to long term nursing facility care to enable a person to live as independently as possible.

1.44 Managed Care Organization (MCO) — An entity that meets the definition of managed care organization as defined at 42 C.F.R. § 438.2 and that has a contract with CMS and ODM to provide services in the Demonstration. It includes the ICDS Plan and may also include other such entities with such contracts.

1.45 Managed Care Provider Network (MCPN) Database — A centralized database system that maintains information on the status of all ICDS Plan- contracted providers.

1.46 Mandated Reporting — Immediate reporting required from a mandated reporter of suspected maltreatment when the mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be Abused or Neglected

1.47 Marketing, Outreach, and Beneficiary Communications — Any informational materials targeted to Beneficiaries that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260.

1.48 Medically Necessary Services —Services delivered in accordance with Appendix A of this document, and consistent with Medicare and Medicaid law, coverage rules and guidelines.

1.49 Medicare-Medicaid Coordination Office — Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Patient Protection and Affordable Care Act.

1.50 Medicare-Medicaid Beneficiary — For the purposes of this Demonstration, an individual who is entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, and enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a state plan under title XIX of such Act or under a waiver of such plan.

1.51 Medicaid — The program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

1.52 Medicare — Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare Beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

1.53 Medicare Advantage — The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 C.F.R. § 422.

1.54 Medicare Waiver — Generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

1.55 Medicaid Waiver — Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act.

1.56 Member Enrollment Mix Adjustment (MEMA) — The MEMA utilizes the particular waiver enrollment and nursing facility placement of the NFLOC member to provide more revenue to plans that have a greater proportion of high risk/cost Beneficiaries and, conversely, less revenue to plans that have a lower proportion of high risk/cost Beneficiaries. The adjustment is budget neutral.

1.57 Minimum Data Set (MDS) — A clinical screening system, mandated by federal law for use in nursing facilities, that assesses the key domains of function, health, and service

use. MDS assessment forms include the MDS-HC for home care and the MDS 3.0 for Nursing Facility Residents.

1.58 MyCare Ohio—the name for the Integrated Care Delivery System managed care program operating in seven (7) Ohio regions that coordinates the physical, behavioral and long-term care services for individuals over the age of 18 who are eligible for both Medicaid and Medicare.

1.59 Notice of Action—notice supplied in accordance with 42 C.F.R. §§ 438.404 and 422.570, the ICDS Plan must give the Beneficiary written notice of any Adverse Action.

1.60 Ohio Department of Insurance (ODI) —The agency responsible for regulation of all insurers operating in the state of Ohio.

1.61 Ohio Medicaid – The Ohio Department of Medicaid (ODM), the agency responsible for administering the Medicaid program in the state of Ohio.

1.62 Ohio Administrative Code (OAC)—Contains all codified Ohio rules and regulations that have been adopted by Ohio state administrative agencies and promulgated in the Register of Ohio.

1.63 Ohio Revised Code (ORC) — Contains all codified Ohio statutes of a general and permanent nature passed by the Ohio General Assembly and signed by the governor.

1.64 Opt Out — A process by which Beneficiaries can choose not to participate in the Demonstration and receive their Medicare benefits through Fee for Service (FFS) Medicare and a standalone Part D Plan; Program of All-inclusive Care for the Elderly (PACE); or a Medicare Advantage Part D plan and only receive Medicaid services through the ICDS Plan in which they are enrolled.

1.65 Ombudsman — The entity designated by the State, and independent of ODM, that advocates and investigates on behalf of Beneficiaries to safeguard due process and to serve as an early and consistent means of identifying systematic problems with the Demonstration.

1.66 Passive Enrollment — An Enrollment process through which an eligible individual is enrolled by ODM (or its authorized agent) into an ICDS Plan, following a minimum sixty (60) day advance notification that includes the opportunity to choose or decline enrollment into an ICDS Plan prior to the effective date.

1.67 Post Stabilization Services — Covered services, related to an emergency medical condition that are provided after a Beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 438.114 to improve or resolve the Beneficiary's condition.

1.68 Preadmission Screening and Resident Review (PASRR) — Federal requirement that helps ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings, described in 42 C.F.R. § 483.100-138.

1.69 Prevalent Languages —Spanish and other additional languages, as determined by ODM. Such additional languages exist where there is a prevalent single-language minority within the enrolled population in the relevant local office area, which for purposes of this Contract shall exist when five percent (5%) or more such households speak a language other than English.

1.70 Prior Authorization — An ICDS Plan's decision to approve or deny a request for a covered service, also referred to as Coverage Determination.

1.71 Privacy — Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant Ohio privacy and confidentiality laws.

1.72 Program of All-Inclusive Care for the Elderly (PACE) — A comprehensive service delivery and financing model that integrates medical and LTSS under dual capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals age 55 and over who meet the nursing-facility level of care criteria and reside in a PACE service area.

1.73 Protected Health Information (PHI) — Except as otherwise provided in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which shall govern the definition of PHI, information created or received from or on behalf of a Covered Contractor as defined in 45 C.F.R. § 160.103, that relates to (i) the provision of health care to an individual; (ii) the past, present or future physical or mental health or condition of an individual; or (iii) the past, present or future payment for the provision of health care to an individual. PHI includes demographic information that identifies the individual or that there is a reasonable basis to believe can be used to identify the individual. PHI is the information transmitted or held in any form or medium.

1.74 Provider — A person or other entity enrolled with CMS to provide Medicare Covered Services, or issued a provider or identification number by the ODM to provide Medicaid Covered Services, to a Beneficiary.

1.75 Quality Assessment and Performance Improvement (QAPI) Program — The program required by 42 C.F.R. § 438.240, in which the ICDS Plan is required to have an ongoing quality assessment and performance improvement program for the services furnished to Beneficiaries, that: (i) assesses the quality of care and identifies potential areas for improvement, ideally based on solid data and focused on high volume/high risk

procedures or other services that promise to substantially improve quality of care, using current practice guidelines and professional practice standards when comparing to the care provided; and (ii) corrects or improves processes of care and clinic operations in a way that is expected to improve overall quality.

1.76 Qualified Family Planning Providers (QFPPs) - 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 Ohio Department of Health (ODH).

1.77 Quality Improvement Organization (QIO) — A statewide organization that contracts with CMS to evaluate the appropriateness, effectiveness, and quality of care provided to Medicare Beneficiaries.

1.78 Readiness Review — Prior to being eligible to accept Demonstration Enrollments, each prospective ICDS Plan selected to participate in the Demonstration must undergo a Readiness Review. The Readiness Review evaluates each prospective ICDS Plan's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Beneficiaries, and provide adequate access to all Medicare and Medicaid-covered Medically Necessary Services. CMS and ODM use the results to inform their decision of whether the prospective ICDS Plan is ready to participate in the Demonstration. At a minimum, each Readiness Review includes a desk review and potentially a site visit to the prospective ICDS Plan's headquarters

1.79 Service Area — The specific geographical area of Ohio designated in the CMS HPMS, and as referenced in Appendix I, for which the ICDS Plan agrees to provide Covered Services to all Beneficiaries who select or are passively enrolled with the ICDS Plan.

1.80 Solvency — Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by the State and agreed to by CMS.

1.81 State — The State of Ohio.

1.82 State Enrollment Vendor — A contract entered into by the State to perform Enrollment of eligible individuals and to provide information and support to eligible individuals and Beneficiaries.

1.83 State Plan — The Ohio Medicaid State Plan filed with Federal CMS, in compliance with Title XIX of the Social Security Act.

1.84 Three-way Contract (Contract) — The three-way agreement that CMS and ODM enter into with an ICDS Plan specifying the terms and conditions pursuant to which a participating ICDS Plan may participate in this Demonstration. The three-way agreement is also a Provider Agreement pursuant to Ohio Revised Code 5167.01.

1.85 Total Capitation Rate Revenue — The sum of the monthly capitation payments for each Demonstration Year (reflecting coverage of Medicare Parts A/B services, Medicare Part D services and Medicaid services, pursuant to Appendix A of this contract) including: 1) the application of risk adjustment methodologies, as described in Section 4.2.4; and 2) any payment adjustments as a result of the reconciliation described in Section 4.3.14. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.

1.86 Trans-Disciplinary Care Team — A team of appropriately qualified professionals comprised of the Beneficiary, the family/caregiver, the ICDS Plan Care Manager, the waiver service coordinator if appropriate, the primary care provider, specialists, and other providers, as applicable, that is designed to effectively meet the Beneficiary's needs.

1.87 Urgent Care — Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, Physician's office, or in a hospital emergency department if a clinic or Physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Medical Condition.

1.88 Utilization Management — A comprehensive approach and planned activities for evaluating the appropriateness, need and efficiency of services, procedures and facilities according to established criteria or guidelines under the provisions of the Demonstration. Utilization Management typically includes activities or decisions based upon the analysis of care, and describes proactive procedures, including prior authorization, discharge planning, concurrent review and pre-certification. It also covers proactive processes, such as concurrent clinical reviews and peer reviews.

Section 2. ICDS Plan Responsibilities

Through the MyCare Ohio Program, CMS and ODM will work in partnership to offer Medicare-Medicaid Beneficiaries the option of enrolling in an ICDS Plan, which consists of a comprehensive network of providers. The ICDS Plan will deliver and coordinate all components of Medicare and Medicaid Covered Services for Beneficiaries.

2.1. **Compliance and Program Integrity**

2.1.1. The ICDS Plan must, to the satisfaction of CMS and ODM:

2.1.2. Comply with all provisions set forth in this Contract; and

2.1.3. Comply with all applicable provisions of federal and Ohio laws, regulations, and waivers, including the implementation of a compliance plan. Although the ICDS Plan is not required to be a certified Medicare Advantage ICDS Plan, the ICDS Plan must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422 and Part 423, except to the extent that waivers from these requirements are provided in the MOU (December 11, 2012) signed by CMS and ODM or herein.

2.1.4. Comply with all aspects of the joint Readiness Review.

2.1.5. Comply with all applicable administrative bulletins issued by the CMS and ODM.

2.1.6. Program Integrity. The ICDS Plan agrees that it will develop and implement an effective compliance program that applies to its operations, and to prevent, detect, and correct Fraud, waste and abuse consistent with 42 C.F.R. §§ 420, et seq § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. § 455 and the contents of this Contract. The compliance program must, at a minimum, include written policies, procedures, and standards of conduct that:

2.1.6.1. Demonstrate the ICDS Plan's compliance with all applicable federal and state standards, including but not limited to:

2.1.6.1.1. Fraud detection and investigation;

2.1.6.1.2. Procedures to guard against Fraud and abuse;

2.1.6.1.3. Prohibitions on certain relationships as required by 42 C.F.R. § 438.610;

2.1.6.1.4. Obligation to suspend payments to Providers;

2.1.6.1.5. Disclosure of ownership and control of the ICDS Plan;

2.1.6.1.6. Disclosure of business transactions;

2.1.6.1.7. Disclosure of information on persons convicted of health care crimes;

2.1.6.1.8. Reporting adverse actions taken for Fraud, integrity, and quality;

2.1.6.2. Describe compliance expectations as embodied in the ICDS Plan's standards of conduct;

2.1.6.3. Implement the operations of the compliance program;

2.1.6.4. Provide guidance to employees and others on dealing with potential compliance issues;

2.1.6.5. Identify how to communicate compliance issues to appropriate compliance personnel;

2.1.6.6. Provide False Claims Education for all employees and First Tier, Downstream and Related Entities as required in 42 U.S.C. § 1396(a)(68);

2.1.6.7. Describe how potential compliance issues are investigated and resolved by the ICDS Plan; and

2.1.6.8. Have a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluation, audits and remedial actions, and reporting to appropriate officials.

2.1.7. Comply with all financial requirements as set forth in Section 2.13 or other requirements as determined by CMS and ODM. If ICDS Plan is found noncompliant it may be subject to an enrollment freeze.

2.2. Contract Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS and ODM, or their designee, will conduct a Readiness Review of each ICDS Plan, which must be completed successfully, as determined by CMS and ODM, prior to the Contract Operational Start Date.

2.2.1.2. CMS and ODM Readiness Review Responsibilities

2.2.1.2.1. CMS and ODM or their designee will conduct a Readiness Review of each ICDS Plan that will include, at a minimum, one on-site review. This review shall be conducted prior to marketing to and enrollment of Beneficiaries into the ICDS Plan. CMS and ODM or their designee will conduct the Readiness Review to verify the ICDS Plan's assurances that the ICDS Plan is ready and able to meet its obligations under the Contract.

2.2.1.2.2. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.2.2.1. Network Provider composition and access, in accordance with Sections 2.6, 2.7, 2.8;

2.2.1.2.2.2. Staffing, including key management positions and functions directly impacting Beneficiaries (e.g., adequacy of Beneficiary Services staffing), in accordance with Sections 2.2.3 and 2.11;

2.2.1.2.2.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Section 2.7 and Appendix C;

2.2.1.2.2.4. Care Coordination capabilities, in accordance with Sections 2.5;

2.2.1.2.2.5. Beneficiary services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.9;

2.2.1.2.2.6. Comprehensiveness of quality management/quality improvement and Utilization Management strategies, in accordance with Section 2.11;

2.2.1.2.2.7. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.10;

2.2.1.2.2.8. Fraud and abuse and program integrity, in accordance with Section 2.1;

2.2.1.2.2.9. Financial solvency, in accordance with Section 2.13;

2.2.1.2.2.10. Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Sections 2.14 and 2.15, including IT testing and security assurances.

2.2.1.2.3. No individual shall be enrolled into the ICDS Plan unless and until CMS and the ODM determine that the ICDS Plan is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.4. CMS and ODM or their designee will identify to the ICDS Plan all areas where the ICDS Plan has been determined not ready and not able to meet its obligations under the Contract and provide an opportunity for the ICDS Plan to correct such areas to remedy all deficiencies prior to the start of marketing.

2.2.1.2.5. CMS or the ODM may, in its discretion, postpone the date the ICDS Plan may start marketing or the Contract Operational Start Date if the ICDS Plan fails to satisfy all Readiness Review requirements. If, for any reason, the ICDS Plan does not fully satisfy to CMS or the ODM that it is ready and able to perform its obligations under the Contract prior to the start of marketing or the Contract Operational Start Date, and CMS or the ODM does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or the ODM may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.1. ICDS Plan Readiness Review Responsibilities

2.2.1.1.1. Demonstrate to CMS and ODM's satisfaction that the ICDS Plan is ready and able to meet all Contract requirements identified in the Readiness Review prior to the ICDS Plan engaging in marketing of its Demonstration product, and prior to the Contract Operational Start Date.

2.2.1.1.2. Provide CMS and ODM or its designee with the corrected materials requested by the Readiness Review report.

2.2.2. Contract Management

2.2.2.1. The ICDS Plan must employ a qualified individual to serve as the Contract Compliance Officer of its ICDS Plan and this Contract. The Contract Compliance Officer must be primarily dedicated to this Contract, hold a senior management position in the ICDS Plan's organization, and be authorized and empowered to represent the ICDS Plan in all matters pertaining to this Contract. The Contract Compliance Officer must act as liaison between the ICDS Plan, CMS, and the ODM, and has responsibilities that include, but are not limited to, the following:

2.2.2.1.1. Ensure the ICDS Plan's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.1.2. Ensure that all ICDS Plan employees direct all day-to-day submissions and communications to the Contract Management Team (CMT) or its designee unless otherwise notified by ODM or CMS. Third party vendors that contract with ODM should not be contacted by the ICDS Plan unless ODM has specifically instructed the ICDS Plan to contact these entities directly;

2.2.2.1.3. Oversee all activities by the ICDS Plan and its First Tier, Downstream, and Related Entities. The ICDS Plan is ultimately

responsible for meeting program requirements, ODM and CMS will not discuss ICDS Plan issues with the ICDS Plan's First Tier, Downstream or Related Entities unless the ICDS Plan is also participating in the discussion.

2.2.2.1.4. Attend all meetings and events designated by ODM or CMS that require mandatory attendance.

2.2.2.1.5. Ensure the availability to CMS and ODM upon either's request, of those members of the ICDS Plan's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Beneficiary services, Utilization Management, Provider Network management, and benefit coordination;

2.2.2.1.6. Coordinate requests and activities among the ICDS Plan, all First Tier, Downstream, and Related Entities, CMS, and ODM;

2.2.2.1.7. Receive and respond to all inquiries and requests made by CMS and ODM in time frames and formats reasonably acceptable to the parties;

2.2.2.1.8. Promptly resolve any issues or identified noncompliance related to the Contract identified by the ICDS Plan, CMS, or ODM;

2.2.2.1.9. Meet with CMS and ODM at the time and place requested by CMS and the ODM, if CMS or ODM or both, determine that the ICDS Plan is not in compliance with the requirements of the Contract; and

2.2.2.1.10. Coordinate the tracking and submission of all contract deliverables, and the preparation and execution of contract requirements, random and periodic audits and site visits.

2.2.3. Organization Structure

2.2.3.1. The ICDS Plan shall establish and maintain the interdepartmental structures and processes to support the operation and management of its MyCare Ohio line of business in a manner that fosters integration of physical health, behavioral health, and LTSS services. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment, when such data is available and does not conflict with coverage requirements specified by CMS or ODM.

2.2.3.2. On an annual, and an ad hoc basis when changes occur, or as directed by ODM or CMS, the ICDS Plan shall submit to the CMT an overall organizational chart that includes senior and mid-level managers for the organization.

2.2.3.3. The ICDS Plan must have an administrative office located in Ohio.

2.2.3.4. Staffing Requirements:

2.2.3.4.1. The ICDS Plan must maintain and have the following positions based and working in the State of Ohio, effective 60 days prior to any initial enrollment:

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

2.2.3.4.1.2. Medical Director/Chief Medical Officer (CMO) who is a physician with a current, unencumbered license through the Ohio State Medical Board. The CMO must have at least three (3) years of training in a medical specialty. The CMO shall devote full time (minimum thirty-two (32) hours weekly) to the ICDS Plan's operations to ensure timely medical decisions, including after-hours consultation as needed. The CMO shall be actively involved in all major clinical and quality management components of the ICDS Plan. At a minimum, the CMO shall be responsible for the:

2.2.3.4.1.2.1. 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;

2.2.3.4.1.2.2. Oversight of the administration of all medical management activities of the ICDS Plan; and

2.2.3.4.1.2.3. Serve as director of the Utilization Management committee and chairman or co-chairman of the Quality Assessment and Performance Improvement (QAPI) Committee as described in Section 2.11.1.

2.2.3.4.1.3. Contract Compliance Officer who will serve as the primary point-of-contact for all ICDS Plan operational issues. The primary functions of the Contract Compliance Officer are described in Section 2.2.2.1.

2.2.3.4.1.4. Provider Services Representatives who resolve Provider issues, including, but not limited to, problems with claims payment, prior authorization, and provider appeals. The ICDS Plan must employ an adequate number of qualified service representatives to meet the needs of medical, behavioral, LTSS.

2.2.3.4.1.5. Care Management Director who works in Ohio and is filled by an individual who is an Ohio-licensed registered nurse, preferably with a designation as a Certified Case Manager (CCM) from the Commission for Case Manager Certification (CCMC). The Care Management Director is responsible for overseeing the day-to-day operational activities of the Care Management Program in accordance with state guidelines. The Care Management Director is responsible to ensure the functioning of Care Management activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating).The Care Management Director must have experience in the activities of Care Management as specified in 42 C.F.R. § 438.208. Primary functions of the Care Management Director position are:

2.2.3.4.1.5.1. To ensure implementation of mechanisms for identifying, assessing, and developing a care plan for an individual with special health care needs.

2.2.3.4.1.5.2. To ensure access to primary care and coordination of health care services for all Beneficiaries.

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

2.2.3.4.1.6. Quality Improvement (QI) Director who is an Ohio-licensed registered nurse, physician or physician's assistant or is 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 Quality Improvement Director must have experience in quality management and quality improvement as specified in 42 C.F.R. §§ 438.200 – 438.242 and 42 C.F.R. § 422.152. The primary functions of the Quality Improvement Director position are:

2.2.3.4.1.6.1. Ensuring individual and systemic quality of care;

2.2.3.4.1.6.2. Integrating quality throughout the ICDS Plan;

2.2.3.4.1.6.3. Implementing process improvement; and

2.2.3.4.1.6.4. Resolving, tracking and trending quality of care Grievances.

2.2.3.4.1.6.5. This individual shall also be responsible for:

2.2.3.4.1.6.5.1. Overseeing all QI activities related to Beneficiaries, ensuring compliance with all such activities, and maintaining accountability for the execution of, and performance in, all such activities;

2.2.3.4.1.6.5.2. Maintaining an active role in the ICDS Plan's overall QI structure;

2.2.3.4.1.6.5.3. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

2.2.3.4.1.6.5.3.1. Physical and behavioral health care;

2.2.3.4.1.6.5.3.2. Pharmacy management;

2.2.3.4.1.6.5.3.3. Care management;

2.2.3.4.1.6.5.3.4. Long-term services and supports;

2.2.3.4.1.6.5.3.5. Financial;

2.2.3.4.1.6.5.3.6. Statistical/analytical;

2.2.3.4.1.6.5.3.7. Information systems;

2.2.3.4.1.7. LTSS/HCBS Director who is an Ohio licensed nurse, Licensed Independent Social Worker (LISW); or has a Master's degree in a health related field. The LTSS/HCBS Director must have at least five (5) years of experience in home and community based services. The primary functions of the LTSS/HCBS Director are:

2.2.3.4.1.7.1. Implementation and oversight of all clinical management functions for Beneficiaries receiving LTSS including but not limited to: assessment, service planning, care coordination, transition planning, consumer hearings, Beneficiary and caregiver education and training;

2.2.3.4.1.7.2. Implementation and oversight of all Provider management functions for Providers of HCBS services including

but not limited to: (i) Provider Enrollment, orientations and monitoring and (ii) operation of an incident management, investigation and response system; and

2.2.3.4.1.7.3. Implementation and oversight of all program management functions including but not limited to:

2.2.3.4.1.7.3.1. Compliance with program requirements, rules and regulations;

2.2.3.4.1.7.3.2. Implementation and management of program policies and procedures and protocols that are aligned with federal and state requirements;

2.2.3.4.1.7.3.3. Beneficiary complaint process; and

2.2.3.4.1.7.3.4. Community education.

2.2.3.4.1.8. Behavioral Health Director who possesses an independent license to provide behavioral health services in the State of Ohio (MD, DO, RN with Advanced Practice Certification, Psychologist, LISW, PCC, IMFT) and has a minimum of five years (5) experience in the provision and supervision of treatment service for mental illness and substance use disorders. The Behavioral Health Director shall demonstrate knowledge and understanding of Ohio's overall behavioral health 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 behavioral health services across the full spectrum of care to Beneficiaries, inclusive of mental health and substance abuse services. The primary functions of the Behavioral Health Director are:

2.2.3.4.1.8.1. Ensuring access to behavioral health services including mental health, substance abuse services;

2.2.3.4.1.8.2. Ensuring overall integration of behavioral health services in the ICDS Plan Beneficiary treatment plans;

2.2.3.4.1.8.3. Ensuring systematic screening for behavioral health related disorders by utilizing standardized and/or evidence-based approaches;

2.2.3.4.1.8.4. Promoting preventive behavioral health strategies;

2.2.3.4.1.8.5. Identifying and coordinating assistance for identified Beneficiary needs specific to behavioral health;

2.2.3.4.1.8.6. Interfacing with the Community Behavioral Health Center Health Homes for Beneficiaries with serious and persistent mental illness and community partners; and

2.2.3.4.1.8.7. Participating in management and program improvement activities with the other key staff for enhanced integration and coordination of behavioral health services and achievement of outcomes.

2.2.3.4.2. An individual staff member is limited to occupying only one of the key staff positions listed above unless prior written approval is obtained from ODM. CMS or ODM shall also require the ICDS Plan to designate contact staff for specific program areas.

2.2.4. NCQA Accreditation - The ICDS Plan must hold and maintain, or must be actively seeking and working towards, accreditation by the National Committee for Quality Assurance (NCQA) for the Ohio Medicare or Medicaid line of business. The ICDS Plan must achieve and/or maintain an excellent, commendable or accredited status from NCQA. For the purposes of meeting this accreditation requirement, ODM will only accept the use of the NCQA corporate survey to the extent deemed allowable by NCQA. Upon completion of the accreditation survey, the ICDS Plan must submit to ODM a copy of the "Final Decision Letter" no later than ten (10) calendar days upon receipt from NCQA. Thereafter and on an annual basis between accreditation surveys, the ICDS Plan must submit a copy of the "Accreditation Summary Report" issued as a result of the annual HEDIS update no later than ten (10) calendar days upon receipt from NCQA. Upon ODM's request, the ICDS Plan must provide any and all documents related to achieving accreditation.

2.3. **Enrollment Activities**

2.3.1. Ohio State Enrollment Broker. All Enrollment and disenrollment-related requests, including transfers between ICDS Plans, will be accepted and documented to ODM by the Ohio Enrollment broker. All enrollment transactions with CMS will be processed by ODM.

2.3.1.1. Enrollment Effective Date(s) – Unless authorized by the CMS Retroactive Processing Center (RPC), all Enrollment effective dates are prospective. Beneficiary-elected Enrollment is the first day of the month following a Beneficiary's request to enroll when received up to five (5) days before the end of the month, or the first day of the month following the month in which the Beneficiary is eligible, as applicable for an individual

Beneficiary. Passive Enrollment is effective no sooner than sixty (60) days after Beneficiary notification of the right to select an ICDS Plan.

2.3.1.1.1. ICDS Plan will be required to accept opt-in Enrollments no earlier than sixty (60) days prior to the initial effective date of May 1, 2014, and begin providing coverage for Beneficiaries no earlier than May 1, 2014.

2.3.1.1.2. The State will initially conduct a phase in consisisting of three (3) periods for those Beneficiaries to opt in. The effective dates for these periods are as follows:

2.3.1.1.2.1. Beneficiaries in the Northeast region will have an Enrollment effective date of May 1, 2014.

2.3.1.1.2.2. Beneficiaries in the Northwest, Northeast Central and Southwest regions will have an Enrollment effective date of June 1, 2014.

2.3.1.1.2.3. Beneficiaries in the East Central, Central and West Central regions will have an Enrollment effective date of July 1, 2014.

2.3.1.2. ICDS Plan will not discriminate against Beneficiaries eligible to enroll on the basis of:

2.3.1.2.1. Health status or need for health care services; or

2.3.1.2.2. Race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

2.3.1.3. Passive Enrollment -The State will conduct Passive Enrollment for those Beneficiaries who have not made a plan selection.

2.3.1.3.1. Beneficiaries in all regions will have a passive enrollment effective date of no earlier than January 1, 2015.

2.3.1.3.2. The effective dates above are subject to the ICDS Plan meeting CMS and State requirements including the ICDS Plan's capacity to accept new Beneficiaries, and may be changed at CMS and ODM discretion. Beneficiaries in any participating region may enroll at any time prior to the regional phase-in dates above.

2.3.1.4. ODM will provide notice of the requirement to select an ICDS Plan at least sixty (60) days prior to the effective date of a Passive Enrollment effective date, and will accept Opt Out requests through the last day of the month prior to the effective date of Enrollment. This notice will explain the Beneficiary's options, including the option to Opt Out or disenroll from the Demonstration.

2.3.1.5. Thirty (30) days prior to the Enrollment effective date above, a second notice will be provided to Beneficiaries who have not responded to the initial notice. The notice will include the name of the ICDS Plan in which the Beneficiary will be enrolled unless he/she selects another plan and documents the opportunity to make a different selection of another ICDS plan as well as the option to Opt Out of the Demonstration.

2.3.1.6. The ODM will proceed with Passive Enrollment into the identified ICDS Plan for Beneficiaries who do not make a different choice, with an effective date of the first day of the month referenced in Section 2.3.1.3 above.

2.3.1.7. Requests to change ICDS Plans or Opt Out will be accepted at any point after Enrollment occurs and are effective on the first of the following month. Any time a Beneficiary requests to Opt Out of the Demonstration, the ICDS Plan will send a letter confirming the Opt Out and providing information on the benefits available to the Beneficiary once they have opted out.

2.3.1.8. Beneficiaries who otherwise are included in Medicare reassignment effective January 1, 2014 or from their current (2013) Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP will be eligible for Passive Enrollment, with an opportunity to Opt Out, into an ICDS Plan effective, as follows:

2.3.1.8.1. Those reassigned to a new PDP effective January 1, 2014, will be eligible for Passive Enrollment into an ICDS Plan effective January 1, 2015.

2.3.1.8.2. The ODM and CMS must agree in writing to any changes to the Enrollment effective dates. CMS will provide identifying information to the ODM about eligible Beneficiaries no later than one-hundred and twenty (120) days prior to the date of the first Passive Enrollment period.

2.3.1.8.3. No Enrollments will be accepted within six (6) months (or less) of the end of the Demonstration.

2.3.1.8.4. Notification of plan and Enrollment options will be provided by the ODM to each Beneficiary not less than sixty (60) calendar days prior to the effective date of the proposed Enrollment.

2.3.1.8.5. Passive Enrollment activity will be coordinated with CMS activities such as annual reassignment and daily auto-assignment for Beneficiaries with the Part D Low Income Subsidy.

2.3.1.8.6. The ODM will develop and apply an “intelligent assignment” algorithm for Passive Enrollment (e.g. that prioritizes continuity of Providers and/or services). The algorithm will consider Beneficiaries’

previous managed care Enrollment and historic Provider utilization, including Medicare Providers and service utilization, to assign Beneficiaries to an ICDS Plan. ODM will use CMS provided crossover claims to develop the algorithm. The number of Beneficiaries enrolled with the ICDS Plan will be limited to a level that will not exceed the ICDS Plan's physical and professional capacity, as reasonably determined by CMS and ODM in consultation with the ICDS Plan.

2.3.1.8.6.1. Adjustments to the volume of Passive Enrollment based on the capacity of the ICDS Plan will be subject to any capacity determinations including but not limited to those documented in the CMS and ODM final Readiness Review report and ongoing monitoring by CMS and the ODM.

2.3.1.8.6.2. The ICDS Plan may, via the CMT, request a capacity limit pursuant to 42 C.F.R. § 422.60. For the purposes of this Demonstration, CMS and the ODM will consider a number of factors, including financial stability and network adequacy, in the determination of a capacity limit.

2.3.1.8.7. ODM and CMS, through the CMT, will review documentation provided by the ICDS Plan that sets forth the ICDS Plan's physical and professional capacity: (i) before the first Enrollment and as regularly provided subsequently; (ii) when the ICDS Plan requests a review and the CMT agrees to such review; (iii) when there is a change in Covered Services, categories of potential Beneficiaries, Service Area or Capitation Rate that can reasonably be expected to impact the ICDS Plan's capacity; (iv) when there is a change of control, or a sale or transfer of the ICDS Plan; and (v) when the CMT determines that the ICDS Plan's operating or financial performance reasonably indicates a lack of Provider or administrative capacity. Such documentation must demonstrate that the ICDS Plan offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of Beneficiaries in the Service Area and that the ICDS Plan maintains a Provider Network as described in Section 2.6 that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Beneficiaries in the Service Area. In the event the CMT reasonably find that the ICDS Plan has failed to restore Provider or administrative capacity, the CMT may freeze Passive Enrollment during the implementation phase or take other corrective action.

2.3.1.8.8. Upon receipt of instruction by the ODM, the Ohio State Enrollment Broker may not process new Enrollments within six (6) months

(or less) before the end date of the Demonstration, unless the Demonstration is extended. CMS and the ODM, upon agreement by both parties, may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the ICDS Plan in making any such adjustments.

2.3.1.8.9. The ODM will provide customer service, including mechanisms to counsel Beneficiaries notified of Passive Enrollment and to receive and communicate Beneficiary choice of Opt Out to CMS via transactions to CMS' MARx system. Beneficiaries will also be provided a notice upon the completion of the Opt Out process. Medicare resources, including 1-800-Medicare, will remain a resource for Medicare Beneficiaries; calls related to ICDS Enrollment will be referred to the Ohio State Enrollment Vendor for customer service and Enrollment support.

2.3.1.8.10. CMS and the ODM will jointly approve all Demonstration notices to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook. CMS may also send a jointly-approved notice to Beneficiaries, and will coordinate such notice with any State notice(s).

2.3.1.8.11. ODM, CMS and ICDS Plan systems will be reconciled on a timely basis to resolve discrepancies between systems on a daily basis.

2.3.2. Disenrollment (Opt Out of the Demonstration)

2.3.2.1. Disenrollments, Opt Out requests and transfers between ICDS Plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these Beneficiaries will continue through the end of the month.

2.3.2.2. CMS and the ODM will monitor Enrollments, disenrollments and Opt Out requests for both evaluation purposes and for compliance with applicable marketing and Enrollment laws, regulations and CMS policies, for the purposes of identifying any inappropriate or illegal marketing practices.

2.3.2.3. The ICDS Plan shall have an Electronic Data Interchange mechanism for receiving timely information about all Enrollment and Opt Out transactions from ODM, including the effective date of Enrollment and Opt Out from CMS, ODM and the Ohio State Enrollment Vendor's systems on a daily basis.

2.3.2.4. Except for transactions received by request to CMS for enrollment in MA-PD plans, all Opt Out requests will be accepted by the ODM Enrollment Broker.

2.3.2.5. Beneficiaries can elect to Opt Out of the ICDS Plan or disenroll from the Demonstration at any time or enroll in another ICDS Plan, a MA-PD plan, PACE,

or may elect to receive services through Medicare Fee-For-Service and a PDP. Beneficiaries will continue to be enrolled in the ICDS Plan for Medicaid services.

2.3.2.6. Disenrollment or Opt Out requests received by the Ohio State Enrollment Vendor or received by CMS, or the CMS contractor, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.2.7. The ICDS Plan shall cease providing Medicare Covered Services to a Beneficiary upon the effective date of the disenrollment or Opt Out request.

2.3.2.8. The ICDS Plan shall notify the County Department of Job and Family Services of any Beneficiary who is no longer eligible to remain enrolled in the ICDS Plan per CMS Enrollment guidance, in order for the ODM to disenroll the Beneficiary. This includes where a Beneficiary remains out of the Service Area or for whom residence in the ICDS Plan Service Area cannot be confirmed for more than six (6) consecutive months.

2.3.2.9. The ODM and CMS shall terminate a Beneficiary's coverage from the ICDS Plan upon the occurrence of any of the following conditions:

2.3.2.9.1. Upon the Beneficiary's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Beneficiary dies. Termination may be retroactive to this date.

2.3.2.9.2. When a Beneficiary elects to change ICDS Plans. Termination of coverage with the previous ICDS Plan shall take effect at 11:59 p.m. on the day immediately preceding the Beneficiary's effective date of Enrollment with the new ICDS Plan.

2.3.2.9.3. When a Beneficiary requests a new MA-PD plan plan through 1-800-MEDICARE. Termination of coverage with the previous ICDS Plan's Medicare coverage shall take effect at 11:59 p.m. on the day immediately preceding the Beneficiary's effective date of Enrollment with the new plan.

2.3.2.9.4. When a Beneficiary elects to receive his or her Medicare services through Medicare Fee-for-Service and/or a separate Medicare PDP termination of Medicare coverage with the ICDS Plan shall take effect at 11:59 p.m. on the day immediately preceding the Beneficiary's effective date of Enrollment with Medicare.

2.3.2.9.5. When a Beneficiary remains out of the Service Area or for whom residence in the plan Service Area cannot be confirmed for more than six (6) consecutive months.

2.3.2.9.6. When a Beneficiary no longer resides in the Service Area, unless a Beneficiary needs to be temporarily moved for health and safety

concerns. If a Beneficiary is to be disenrolled at the request of the ICDS Plan under the provisions of this Section, the ICDS Plan must first provide documentation satisfactory to the County Department of Job and Family Services that the Beneficiary no longer resides in the Service Area. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the County Department of Job and Family Services determines that the Beneficiary no longer resides in the Service Area. Termination may be retroactive if the County is able to determine the month in which the Beneficiary moved from the Service Area.

2.3.2.9.7. When ODM or CMS determines that a Beneficiary has other significant insurance coverage or is placed in Spend-down status, ODM shall notify the ICDS Plan of the effective date of termination.

2.3.2.9.8. When CMS or the County Department of Job and Family Services is made aware that a Beneficiary is incarcerated in any county jail, Ohio Department of Corrections facility, another state's correctional facility, or federal penal institution, termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Beneficiary was incarcerated.

2.3.2.9.9. The termination or expiration of this Contract terminates coverage for all Beneficiaries enrolled with the ICDS Plan. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the parties.

2.3.2.10. Except as otherwise provided in Section 2.3, termination of a Beneficiary's coverage shall take effect at 11:59 p.m. on the last day of the month in which the Opt Out or disenrollment request is processed by ODM or designee.

2.3.2.11. The ICDS Plan shall not seek to terminate Enrollment because of an adverse change in a Beneficiary's health status or because of the Beneficiary's utilization of Covered Services, diminished mental capacity, uncooperative or disruptive behavior resulting from such Beneficiary's special needs (except to the extent such Beneficiary's continued Enrollment with the ICDS Plan seriously impairs the ICDS Plan's ability to furnish Covered Services to the Beneficiary or other Beneficiaries as defined in Section 2.4), or take an Adverse Action in connection with a Beneficiary who attempts to exercise, or is exercising, his or her Appeal or Grievance rights. Any attempts to seek to terminate Enrollment in violation of this Section will be considered a breach of this Contract.

2.3.2.12. The ICDS Plan, however, may submit a written request, accompanied by supporting documentation, to ODM and CMS, via the CMT, to disenroll a Beneficiary, for cause, if:

2.3.2.12.1. The Beneficiary's continued Enrollment seriously impairs the ICDS Plan's ability to furnish Covered Services to either this Beneficiary or other Beneficiaries, provided the Beneficiary's behavior is determined to be unrelated to an adverse change in the Beneficiary's health status, or because of the Beneficiary's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

2.3.2.13. The ODM and CMS, through the CMT will determine when and if the ICDS Plan's request to terminate the Enrollment of a Beneficiary will be granted based on the criteria in Section 2.3.2.

2.3.2.14. The ODM and CMS will develop a process to evaluate disenrollment requests for Beneficiaries whose continued Enrollment seriously impairs the ICDS Plan's ability to furnish services to this Beneficiary or other Beneficiaries.

2.3.2.15. If the ODM and CMS determine that the ICDS Plan too frequently requests termination of Enrollment for Beneficiaries, the ODM and CMS reserve the right to deny such requests and require the ICDS Plan to initiate steps to improve the ICDS Plan's ability to serve such Beneficiaries.

2.3.2.16. To support the ODM's and CMS' evaluation of the ICDS Plan's requests for involuntary disenrollment, the ICDS Plan shall:

2.3.2.16.1. In all cases, document what steps the ICDS Plan has taken to locate and contact the Beneficiary, and the impact of or response to each attempt; and

2.3.2.16.2. Provide a quarterly report to the CMT of all Beneficiaries who have not participated in either the Comprehensive Assessment or the care planning process or both, and whether this is because the ICDS Plan could not locate or engage the Beneficiary, because the Beneficiary declined, or for another reason. The ICDS Plan must transfer Beneficiary record information promptly to the new Provider upon written request signed by the disenrolled Beneficiary.

2.3.2.17. If the Beneficiary transfers to another ICDS Plan, with the Beneficiary's written consent, and in accordance with applicable laws and regulations, the ICDS Plan must promptly transfer current Individualized Care Plan (ICP) information to the new ICDS Plan.

2.4. **Covered Services**

2.4.1. The ICDS Plan must authorize, arrange, and coordinate the provision of all Covered Services for its Beneficiaries. (See Covered Services in Appendix A.) Covered Services must be available to all Beneficiaries, as authorized by the ICDS Plan. Covered Services will be managed and coordinated by the ICDS Plan through the Trans-Disciplinary Care Team (see Section 2.5). The ICDS Plan must provide Medicare and Medicaid Covered Services as documented in state and federal law, federal regulation (including, but not limited to, 42 C.F.R §§ 422, 423, and 438), OAC 5160-58-03, and this Contract, and shall be sufficient to achieve the purposes for which such Covered Services are furnished. This duty shall commence at the time of initial coverage as to each Beneficiary.

2.4.2. The ICDS Plan must provide the full range of Covered Services. If either Medicare or Medicaid provides more expansive coverage for services than the other program does for a particular condition, type of illness, or diagnosis, the ICDS Plan must provide the most expansive set of services required by either program. The ICDS Plan may not limit or deny services based on Medicare or Medicaid providing a more limited range of services than the other program. For overlapping Medicare and Medicaid services, the ICDS Plan shall develop policies and procedures that minimize administrative burdens and streamline how providers deliver and beneficiaries receive these services.

2.4.2.1. The ICDS plan shall also develop authorization and payment procedures to assure that services that are covered by both Medicare and Medicaid are reasonably attributed to Medicare as the primary payer for purposes of the encounter reporting required in Sections 2.14 and 2.15, and in accordance with any additional CMS and ODM encounter reporting guidelines.

2.4.2.2. The ICDS Plan is required to provide or arrange for all Medically Necessary Services as described in Appendix A, whether by subcontract or by single-case agreement in order to meet the needs of the Beneficiary.

2.4.3. Out of Network Reimbursement Rules. The ICDS Plans must reimburse an out-of-network Provider of emergent or Urgent Care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, at the Medicare or Medicaid FFS rate applicable for that service. Where this service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Beneficiaries maintain balance billing protections.

2.5. **Care Delivery Model**

2.5.1 Primary Care:

2.5.1.1. The ICDS Plan must ensure that each Beneficiary has a Network primary care provider (PCP) of their choice who will serve as an ongoing source of primary and preventive care and will perform care coordination activities appropriate to the Beneficiary's needs. The PCP's care coordination responsibilities include, at a minimum, the following:

2.5.1.1.1. Assisting with coordination of the Beneficiary's overall care, as appropriate;

2.5.1.1.2. Recommending referrals to specialists, non-physician provider types (e.g., nutritionists, physical therapists) and to laboratory, imaging, radiology, and other diagnostic procedures, as necessary;

2.5.1.1.3. Triaging Beneficiaries according to the following:

2.5.1.1.3.1. Emergency care needs must be triaged and treated immediately on presentation at the PCP site;

2.5.1.1.3.2. Persistent symptoms must be treated no later than the end of the following working day after the initial contact with the PCP site; and

2.5.1.1.3.3. Requests for routine care must be seen within six (6) weeks.

2.5.1.1.4. Participating in the development of an ICP, and as a member of the Trans-Disciplinary Care Team.

2.5.1.2. Beneficiaries will be allowed to select a PCP from the ICDS Plan's network of Providers, and to change the PCP no less often than monthly. Beneficiaries who do not select a PCP will be assigned a PCP by the ICDS Plan prior to the effective date of enrollment.

2.5.2. Health Promotion and Wellness Activities

2.5.2.1. The ICDS Plan must develop and offer a range of health and wellness programs and informational materials that target specific health needs and risk behaviors identified for the ICDS Plan's membership. At a minimum, the ICDS Plan must ensure that an assessment of the overall Beneficiary's health needs is conducted and that the results are used to inform the development and/or refine of the health and wellness programs and informational materials. The ICDS Plan should ensure the following related to the health promotion and wellness activities:

2.5.2.1.1. The content for these programs and informational materials must be evidence-based and support a Beneficiary in making informed decisions about access and utilizing health care services appropriately.

2.5.2.1.2. Care Management staff are informed of the ICDS Plan's health and wellness programs and informational materials in order to facilitate appropriate referrals to the programs or provide informational materials through the Care Management process.

2.5.3. Care Management

2.5.3.1. The ICDS Plan must provide Care Management services to all Beneficiaries enrolled in the ICDS Plan. The ICDS Plan's approach to Care Management must be person-centered, promote the Beneficiary's ability to live independently and comprehensively coordinate the full set of Medicare and Medicaid benefits across the continuum of care including medical, behavioral, LTSS, and social needs.

2.5.3.2. The ICDS Plan must address the following components as part of its Care Management model:

2.5.3.2.1. Identification Strategy: The ICDS Plan must develop and implement an identification strategy that is multi-faceted and minimally uses a combination of predictive modeling software; health risk assessment tools; functional assessments; referrals from individuals, family members and Providers; administrative claims data, etc.

2.5.3.2.1.1. The identification strategy must consider the medical, behavioral health (i.e., mental health and substance use), LTSS and social needs.

2.5.3.2.1.2. The ICDS Plan must use the results of the identification process to assign an initial risk level as described below to each Beneficiary for the purpose of determining the timeframe and mode by which Beneficiaries will receive an initial Comprehensive Assessment.

2.5.3.2.1.3. Timeframes required by ODM for completion of the initial Comprehensive Assessment are established in Section 2.5.3.2.3.

2.5.3.2.2. Risk Stratification levels: The ICDS Plan must develop a risk stratification level framework for the purpose of targeting interventions and allocating resources based on the Beneficiary's needs.

2.5.3.2.2.1. ODM developed a risk stratification level framework that contains five (5) levels (i.e., from lowest to highest: monitoring,

low, medium, high, and intensive) and for each of the five (5) levels established standards for the completion of the assessment, the contact schedule and staffing ratios. The risk stratification level developed by the ICDS Plan must consist of at least three (3) stratification levels:

2.5.3.2.2.1.1. The highest tier must meet or exceed the standards established by ODM for the intensive level;

2.5.3.2.2.1.2. The medium tier must meet or exceed the standards established by ODM for the medium level; and

2.5.3.2.2.1.3. The lowest tier must meet or exceed the standards established by ODM for the monitoring level.

2.5.3.2.2.2. The ICDS Plan may develop an alternative naming convention for the stratification levels; however, they must conform to ODM's requirements for each level as specified throughout Section 2.5.3.

2.5.3.2.2.3. The ICDS Plan must consider at a minimum the following factors when determining the initial/permanent assignment of a Beneficiary to a stratification level:

2.5.3.2.2.3.1. Duration of 1915(c) HCBS waiver Enrollment;

2.5.3.2.2.3.2. Current waiver acuity level;

2.5.3.2.2.3.3. Change in existing Care Manager relationship;

2.5.3.2.2.3.4. Change in caregiver status/support;

2.5.3.2.2.3.5. Presence and severity of chronic conditions;

2.5.3.2.2.3.6. Poly-pharmacy;

2.5.3.2.2.3.7. Nursing facility or assisted living facility placement;

2.5.3.2.2.3.8. Functional and/or cognitive deficits;

2.5.3.2.2.3.9. Displayed risk factors for being institutionalized;

2.5.3.2.2.3.10. Inpatient or emergency department utilization;

2.5.3.2.2.3.11. Residential housing status;

2.5.3.2.2.3.12. Gaps in care; and

2.5.3.2.2.3.13. Stability of support system.

2.5.3.2.2.4. The ICDS Plan must develop criteria and thresholds for each level that will be used to determine how a Beneficiary is assigned to the risk stratification level. Criteria and thresholds established by the ICDS Plan are subject to ODM and CMS approval.

2.5.3.2.2.5. The results of the Comprehensive Assessment process will be used to confirm or modify the Beneficiary's assignment to the risk stratification level. Upon confirmation of the risk level, the ICDS Plan must communicate the risk level to the Trans-Disciplinary Care Team.

2.5.3.2.2.6. The ICDS Plan must continuously evaluate a Beneficiary's assignment to the stratification level as it may need to be adjusted over time due to changes in the Beneficiary's need(s), progress in meeting ICP goals and outcomes, etc.

2.5.3.2.2.7. If as a result, a change in the risk stratification level is warranted, the ICDS Plan must identify the reason(s) for changing the Beneficiary's Care Management risk stratification level assignment (e.g., achieving goals in the ICP, change in health status, etc.); discuss the proposed action with the Beneficiary and the Trans-Disciplinary Care Team, as appropriate; provide reasonable notice about the change in the risk level to the Beneficiary and the Trans-Disciplinary Care Team; and revise the communication plan, if necessary.

2.5.3.2.3. Comprehensive Assessment: The ICDS Plan must conduct or arrange for the completion of a Comprehensive Assessment of medical, behavioral, LTSS and social needs.

2.5.3.2.3.1. At a minimum, the Comprehensive Assessment used by the ICDS Plan must be approved by ODM and CMS and include the following evaluation domains:

2.5.3.2.3.1.1. Behavioral health needs;

2.5.3.2.3.1.2. Medical needs;

2.5.3.2.3.1.3. Functional and cognitive needs;

2.5.3.2.3.1.4. LTSS;

2.5.3.2.3.1.5. Social needs;

2.5.3.2.3.1.6. Nutritional needs;

2.5.3.2.3.1.7. Medical and behavioral health history;

2.5.3.2.3.1.8. Activities of daily living and/or instrumental activities of daily living;

2.5.3.2.3.1.9. Self-care capabilities;

2.5.3.2.3.1.10. Transitional and/or discharge plans;

2.5.3.2.3.1.11. Beneficiary's strength and abilities;

2.5.3.2.3.1.12. Beneficiary's goals, preferences, and desired level of involvement in the care planning process;

2.5.3.2.3.1.13. Willingness/readiness to change behaviors;

2.5.3.2.3.1.14. Caregiver status and capabilities;

2.5.3.2.3.1.15. Informal and formal supports;

2.5.3.2.3.1.16. Health literacy;

2.5.3.2.3.1.17. Health, welfare, and safety;

2.5.3.2.3.1.18. History, suspicion, or detection of abuse, violence, or trauma;

2.5.3.2.3.1.19. Environmental/residential assessment;

2.5.3.2.3.1.20. Spiritual;

2.5.3.2.3.1.21. Cultural;

2.5.3.2.3.1.22. Financial;

2.5.3.2.3.1.23. Special communication needs;

2.5.3.2.3.1.24. Transportation capabilities;

2.5.3.2.3.1.25. Advance care planning; and

2.5.3.2.3.1.26. Wellness and prevention activities.

2.5.3.2.3.2. Comprehensive, relevant and recent data sources will be used to formulate the Comprehensive Assessment, including but not limited to the following: the Beneficiary, Providers (including PCPs and specialists), medical records, claims data, caregivers, family, and Trans-Disciplinary Care Team members.

2.5.3.2.3.3. Results of the Comprehensive Assessment will be used to confirm the Beneficiary's assignment to the risk stratification level and to develop the ICP.

2.5.3.2.3.4. The ICDS Plan must complete an initial Comprehensive Assessment and reassessment according to the timeframes and modes that are specific to each stratification level. Initial Comprehensive Assessments must be completed within fifteen (15) days of the Enrollment effective date for Beneficiaries assigned to

the intensive level, within thirty (30) days for the high level; within sixty (60) days for the medium level; and within seventy-five (75) days for the low and monitoring levels.

2.5.3.2.3.5. A reassessment must be completed within three hundred sixty-five (365) days of the initial Comprehensive Assessment completion date.

2.5.3.2.3.6. Initial Comprehensive Assessments and the annual reassessments must be completed at the location of the Beneficiary's primary place of service (i.e., home or institutional facility) for Beneficiaries who are assigned to the intensive and high risk levels and for any Beneficiaries receiving HCBS waiver services. Initial Comprehensive Assessments and annual reassessments may be completed telephonically for Beneficiaries assigned to the low, medium, or monitoring levels unless an in-person assessment is requested by the Beneficiary, caregiver, or Provider.

2.5.3.2.3.7. Updates to the assessment, as described below, will be completed in person or by telephone. The ICDS Plan must consider why the assessment needs to be updated, the Beneficiary's needs and functional health status, and the preference of the Beneficiary when determining the mode by which the assessment will be completed.

2.5.3.2.3.7.1. Assessments must be updated when there is a change in the Beneficiary's health status or needs, change in diagnosis, change in caregiver status, change in functional status, a significant health care event (e.g., hospital admission or transition between care settings), or as requested by the Beneficiary, his/her caregiver, or his/her Provider.

2.5.3.2.3.7.2. At a minimum for Beneficiaries receiving HCBS waiver services, upon discovery of a potential significant change event, telephone contact between the Care Manager or the Waiver Service Coordinator must occur by the end of the next full calendar day. If it is determined through this telephone contact that a significant change occurred, a face to face visit must take place by the end of third day full day following discovery.

2.5.3.2.3.8. Updates to the assessment must be reflected in the ICP, including the waiver service plan.

2.5.3.2.3.9. Assessments will be completed by appropriately qualified health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials, and are appropriate for responding to or managing the Beneficiary's needs.

2.5.3.2.4. Individualized Care Plan:

2.5.3.2.4.1. The ICDS Plan must develop and implement a person-centered care planning process that yields an integrated ICP for the Beneficiary, is based on the recent Comprehensive Assessment and includes the following elements:

2.5.3.2.4.1.1. Prioritized measureable goals, interventions, and anticipated outcomes with completion timeframes that address the Beneficiary's physical, behavioral, social and LTSS needs along with responsible parties;

2.5.3.2.4.1.2. Integration of the waiver service plan that is developed and implemented in accordance with Section 2.5.3.3.5.4;

2.5.3.2.4.1.3. Identifies and prioritizes the Beneficiary's concerns, strengths, and preferences for care (e.g., cultural considerations).

2.5.3.2.4.1.4. A process to develop, update, and review the ICP (i.e., initial and revised) with the Beneficiary, family/caregivers, the PCP, specialists and members of the Trans-Disciplinary Care Team, as appropriate. Initial ICPs must be developed within fifteen (15) calendar days of the initial Comprehensive Assessment completion date.

2.5.3.2.4.1.5. Implementation and ongoing monitoring of the ICP that includes documentation of the following:

2.5.3.2.4.1.5.1. Assessment of the Beneficiary's progress in achieving goals and outcomes established in the ICP;

2.5.3.2.4.1.5.2. Coordination of care and services (e.g., scheduling appointments, tracking and follow up of referrals, interacting with Providers to facilitate Prior Authorization requests) for the Beneficiary with the Waiver Service Coordinator, PCP, specialist(s), and other service Providers/coordinators, as appropriate;

2.5.3.2.4.1.5.3. Monitoring of the ICP to identify adherence to evidence-based practices, transitions across care settings, barriers to care, appropriate service utilization, quality of services, or gaps in care; and

2.5.3.2.4.1.5.4. Revision to the ICP based on information discovered during ongoing monitoring must occur as expeditiously as the Beneficiary's needs warrant but no later than fourteen (14) calendar days from the date the change in need or health status is identified.

2.5.3.2.4.1.6. Identification of the Providers responsible for delivering services and identification of new/standing referrals to specialists or Providers as well as confirmation that the Beneficiary received the services;

2.5.3.2.4.1.7. A provision to refer the Beneficiary, if applicable, to a community or social services agency, assist the Beneficiary in contacting the agency and validate the Beneficiary received the service;

2.5.3.2.4.1.8. A communication plan developed with the Beneficiary, including the method of preferred contact and a contact schedule that is based on the Beneficiary's needs;

2.5.3.2.4.1.9. An aggressive strategy for effective and comprehensive transitions of care between care setting which includes obtaining the discharge/transition plan; conducting timely follow up with the Beneficiary and his/her Providers, as appropriate; performing medication reconciliation; and ensuring the timely provision of formal and informal supports;

2.5.3.2.4.1.10. Ongoing medication management with the goals of increasing the Beneficiary's compliance with his/her medication regimen and to avoid adverse medication interactions and complications, as well as assuring reconciliation of medications at the point of discharge or transfer between care settings; and

2.5.3.2.4.1.11. Continuous evaluation of the appropriateness of the Beneficiary's current assignment to the risk stratification level as specified in Section 2.5.3.2.2.

2.5.3.3. Provision of Care Management

2.5.3.3.1. Care Manager and the Trans-Disciplinary Care Team

2.5.3.3.1.1. The ICDS Plan must assign a Care Manager who will be the accountable point of contact for the Beneficiary; ensure the integration of the Beneficiary's medical, behavioral health, substance use and LTSS needs; and will lead the Trans-Disciplinary Care Team. Responsibilities for the Care Manager will include but not be limited to the following: delineating roles and responsibilities for members of the Trans-Disciplinary Care Team; directing and delegating Care Management activities; implementing, monitoring, and updating the ICP; exchanging information between Trans-Disciplinary Care Team members; and facilitating Trans-Disciplinary Care Team meetings. The Care Manager must have the appropriate experience and qualifications based upon the Beneficiary's assigned risk level and needs. The ICDS Plan must have a process to ensure that the Beneficiary and/or the authorized representative are able to request a change in the Care Manager.

2.5.3.3.1.2. The ICDS Plan will formulate a Trans-Disciplinary Care Team for each Beneficiary. Each Beneficiary shall have access to, and input to the development of, the Trans-Disciplinary Care Team. Composition of the Trans-Disciplinary Care Team will vary based on the needs and preferences of the Beneficiary but will minimally include the Beneficiary, the PCP, the Care Manager, the Waiver Service Coordinator as appropriate, specialists, family members, caregivers, and any other individuals requested by the Beneficiary. Whereas the Waiver Service Coordinator is not also the Care Manager, the Waiver Service Coordinator will also be a member of the Trans-Disciplinary Care Team. The Trans-Disciplinary Care Team will participate in and support key Care Management activities that are outlined in Section 2.5.3, such as completion of the Comprehensive Assessment and development, implementation and updates to the ICP at the direction of the Care Manager. All members of the Trans-Disciplinary Care Team are responsible for ensuring that care is person-centered, built on the Beneficiary's specific preferences and needs, and delivered with transparency, individualization, respect, linguistic and cultural competence, and dignity.

2.5.3.3.1.3. Staffing Ratios

2.5.3.3.1.3.1. The ICDS Plan must maintain a staffing ratio defined as one full time equivalent (FTE) per the number of Beneficiaries specified below for each risk stratification level:

2.5.3.3.1.3.1.1. 1) Intensive: 1:25 - 1:50

2.5.3.3.1.3.1.2. 2) High: 1:51 - 1:75

2.5.3.3.1.3.1.3. 3) Medium: 1:76 - 1:100

2.5.3.3.1.3.1.4. 4) Low: 1:101 - 1:250

2.5.3.3.1.3.1.5. 5) Monitoring: 1:251 - 1:350

2.5.3.3.1.3.2. The FTE count shall only include staff and their functions that are directly linked to the Care Management activities performed for a Beneficiary in that stratification level. At a minimum, the ICDS Plan must ensure that the FTE count for each stratification level only includes: 1) a person's time who directly interacted with a Beneficiary or who directly participated in the Beneficiary's ICP (e.g., discharge planning, collaborative case conference); and 2) vendors or community partners for which the ICDS Plan has an ODM-approved delegated relationship.

2.5.3.3.1.3.3. The ICDS Plan must submit the staffing model and FTE counts with the submission of the Care Management program structure.

2.5.3.3.1.4. The ICDS Plan is responsible for ensuring that staff who are completing Care Management functions are operating within their professional scope of practice, are appropriate for responding to the Beneficiary's needs, and follow the state's licensure/credentialing requirements.

2.5.3.3.2. Care Management Contact Schedule

2.5.3.3.2.1. The ICDS Plan must establish a contact schedule that is based on the Beneficiary's needs and facilitates ongoing communication with the Beneficiary. At a minimum, the ICDS Plan must adhere to the following contact schedule as specified below for each stratification level:

Risk stratification level	Minimum contact schedule	
	First six months of Enrollment in the risk stratification level (Note: Visit is an in-person contact.)	Month 7 until conclusion of the Demonstration (Note: Visit is an in-person contact)
Intensive	0-1month: 2 visits. Maximum of 15 days between visits.	1 visit each month. Maximum of 30 days between visits.

Risk stratification level	Minimum contact schedule	
	First six months of Enrollment in the risk stratification level (Note: Visit is an in-person contact.)	Month 7 until conclusion of the Demonstration (Note: Visit is an in-person contact)
	2-6 months: 1 visit each month. Maximum of 30 days between visits. Telephonic contact as needed.	Telephonic contact as needed.
High	0-1 month: 2 visits. Maximum of 15 days between visits. 2-3 months: 1 visit per month. Maximum of 30 days between visits. 4-6 months: 2 visits in 90 days. Maximum of 45 days between visits. Telephonic contact as needed.	1 visit every two months. Maximum of 60 days between visits. Monthly telephonic contact.
Medium	0-2 months: 1 visit. 3-6 months: 2 visits. Maximum of 60 days between visits. Telephonic contact as needed.	1 visit every three months. Maximum of 90 days between visits. Monthly telephonic contact.
Low	0-4 months: 1 visit. 5-6 months: 1 telephonic contact.	1 visit every six months. Maximum of 180 days between visits. Quarterly telephonic contact.
Monitoring	0-6 months: 1 visit. Telephonic contact as needed.	1 visit per year. Semi-annual phone contact.

2.5.3.3.2.2. For Beneficiaries who are newly enrolled in the HCBS waiver (i.e., after the effective date of Enrollment with the

ICDS Plan), and who have been assigned to the low and medium risk stratification levels, the minimum contact schedule for the first six (6) months of HCBS waiver Enrollment must be no less frequent than the contact schedule established for the high risk stratification level for the first six (6) months of Enrollment.

2.5.3.3.2.3. At least one of the in-person visits within the first six (6) months of the Demonstration and then annually thereafter must be conducted in the location of the Beneficiary's primary place of service (i.e., residence or institutional facility). Additional in-person visits should occur at a location that is agreed upon by the Beneficiary and the ICDS Plan.

2.5.3.3.2.4. The activity conducted during the in-person visit contact must be linked to the goals, interventions, and outcomes identified in the ICP and must be directed by the Care Manager. In person visits may be conducted by any member of the Trans-Disciplinary Care Team.

2.5.3.3.2.5. The outcome of the in-person visit should be documented, reported back to the ICDS Plan Care Manager, and integrated into the ICP. Upon request, the ICDS Plan must provide a copy of the contact schedule to the Beneficiary.

2.5.3.3.2.6. Contact schedules, and any exceptions to the contact schedule, must be documented in the Beneficiary's Care Management record.

2.5.3.3.3. Care Management Solutions: The ICDS Plan must have in place the following solutions in order to assist with Care Management/Coordination and Provider/Beneficiary Communication.

2.5.3.3.3.1. Centralized Enrollee Record. The ICDS Plan must use information technology systems and processes to integrate the following data elements, at a minimum, into a single, centralized, comprehensive record for each Beneficiary: demographic data; Enrollment data; Care Management data, including assessment results, the ICP, waiver service plan, case notes, Care Manager assignment, etc.; claims and pharmacy data; and authorizations and referrals. The ICDS Plan must ensure that the centralized enrollee record is current, available and accessible twenty-four (24) hours a day, seven (7) days a week in entirety and/or as a summary of key clinical/Care Management data to members of the Trans-Disciplinary Care Team or other authorized personnel in order to facilitate Care Management

needs, respond to urgent/emergent needs, and to ensure effective, safe service delivery. In the event that the ICDS Plan is unable to implement the information technology systems and processes necessary to meet this requirement prior to the Contract Operational Start Date, then ODM and CMS may temporarily waive this requirement to allow the ICDS Plan additional time to bring itself into compliance. The decision to grant additional time to the ICDS Plan, and the duration of such time, will be determined by, and at the discretion of, ODM and CMS. In all cases, the ICDS Plan is expected to make all reasonable efforts to achieve compliance with this requirement as timely as possible.

2.5.3.3.3.2. In order to support point-of-care clinical decision making, the ICDS Plan is expected to participate in the statewide health information exchange when established.

2.5.3.3.3.3. Care Management System. The ICDS Plan must have a Care Management system that captures, at a minimum, for each Beneficiary the results of the assessment, the ICP content, including goals, interventions, outcomes and completion dates, and Beneficiary/provider contact notes. This system must be linked to other databases, systems, and the centralized enrollee record that the ICDS Plan uses to maintain information about the Beneficiary. The goal is to integrate the Beneficiary information in a meaningful way to facilitate Care Management needs. The system(s) must have the capability to share Care Management information with the Beneficiary and any member of the Trans-Disciplinary Care Team, as appropriate.

2.5.3.3.3.4. Care Management Support Line. The ICDS Plan must accommodate in bound communication by Beneficiaries. To support Care Management, the ICDS Plan shall operate a twenty-four (24) hour, seven (7) days a week, toll free call in system available nationwide that is staffed by appropriately trained and qualified health professionals who are able to access the Beneficiary’s records, assess the Beneficiary’s issues, and provide an appropriate course of action (i.e., medical advice, direct the Beneficiary to an appropriate care setting, referral to a member of the Trans-Disciplinary Care Team etc.). The ICDS Plan must ensure that the staff person facilitating a resolution to the identified Care Management need(s) has access to, and is familiar with, the Beneficiary’s ICP. Assurance of the Beneficiary's health, welfare, and safety must be considered when

determining the resolution and completion timeframe, including the provision of in-person support if warranted.

2.5.3.3.4. The ICDS Plan must apply evidence based guidelines or best practices when developing and implementing ICP goals and interventions.

2.5.3.3.5. The ICDS Care Management model will require the ICDS Plan to coordinate services with Medicaid Health Homes, request LOC determinations from the local Areas Agencies of Aging (AAAs), interface with HOME Choice, and manage HCBS waiver services.

2.5.3.3.5.1. Coordination with Medicaid Health Homes. Beneficiaries may be eligible to receive Health Home services as defined in OAC 5122-29-33 if they meet state specified criteria and an approved Health Home operates in the Demonstration County.

2.5.3.3.5.1.1. Eligible Beneficiaries can elect to receive their Care Management from either the ICDS Plan or the Health Home. Beneficiaries who elect to receive Care Management from the Health Home will have all of their behavioral, physical, social, and LTSS needs coordinated by the Health Home. For Beneficiaries who receive HCBS waiver services, and also choose to receive Care Management from the Health Home, the ICDS Plan's Waiver Service Coordinator will be responsible for Waiver Service Coordination and will be a member of the Health Home Care Management team.

2.5.3.3.5.1.2. The ICDS Plan must contract with State-certified Health Home Providers for the provision and payment of Health Home services. The ICDS Plan must reimburse the Health Home Provider as specified by ODM. The contractual arrangement between the Health Home and the ICDS Plan constitutes delegation of Care Management that must adhere to delegation requirements specified in OAC 5160-58-01.1, OAC 5160-26-05 and Appendix C.

2.5.3.3.5.1.3. The ICDS Plan must also perform the following tasks in coordination with the Health Home:

2.5.3.3.5.1.3.1. Designate a Care Management point of contact(s) for each Health Home who shall participate in Health Home Care Management team meetings, facilitate information exchange between the ICDS Plan and Health Home, identify the Beneficiary's Waiver Service Coordinator, as appropriate, etc.

2.5.3.3.5.1.3.2. Routinely transmit the following data and reports to the Health Home;

2.5.3.3.5.1.3.2.1. The most recent assessment, ICP (including the waiver service plan, if appropriate), and progress notes;

2.5.3.3.5.1.3.2.2. Approved Prior Authorizations for future services (e.g., inpatient facility stays);

2.5.3.3.5.1.3.2.3. Timely notification of admissions/discharges for an inpatient facility stay or emergency department visit;

2.5.3.3.5.1.3.2.4. Clinical patient summaries (including diagnosis and medication profiles);

2.5.3.3.5.1.3.2.5. Summaries of Beneficiary contacts with the 24/7 nurse advice line, Care Management department, or the Beneficiary services line that pertain to the delivery or receipt of Health Home services for a Beneficiary;

2.5.3.3.5.1.3.2.6. Other data, information or reports as agreed upon by the Health Home and the ICDS Plan.

2.5.3.3.5.1.3.3. Provide the Health Home with a list of contracted Providers who may provide services to the ICDS Plan Beneficiaries who are receiving Health Home services;

2.5.3.3.5.1.3.4. Develop a plan with the Health Home to effectively transition the Care Management responsibility for a Beneficiary from the ICDS Plan to the Health Home, and vice versa, in order to prevent unnecessary duplication of, or gaps in, services;

2.5.3.3.5.1.3.5. Integrate all information/data transmitted by the Health Home or ODM related to a Beneficiary receiving Health Home services into any appropriate system or database that is maintained by the

ICDS Plan, including Beneficiary assessments, Care Management notes, discharge plans, ICPs, etc;

2.5.3.3.5.1.3.6. Integrate the results from the Health Homes' metrics into the ICDS Plan's overall quality improvement program; and

2.5.3.3.5.1.3.7. Participate in the Medicaid Health Homes Learning Community which will consist of the Health Homes, the Ohio Department of Mental Health and Addiction Services, ICDS Plans and ODM.

2.5.3.3.5.2. Level of Care Request: The ICDS Plan is required to request LOC determinations from their local Area Agencies on Aging. At a minimum, LOC determinations must be requested for Medicaid covered nursing facility stays, Enrollments onto the ICDS HCBS waiver and event-based and annual reassessments for existing waiver Beneficiaries. The ICDS Plan must be familiar with all rules related to nursing facility LOC and the Preadmission Screening and Resident Review (PASRR) processes. Details regarding the LOC request process will be made available in the Care Management/Waiver Service Coordinator guide developed by ODM.

2.5.3.3.5.3. Interface with the HOME Choice Program. In order to access the HOME Choice program, Ohio's Money Follows the Person Transition Program, for a Beneficiary who resides in a nursing facility and desires to relocate to a community setting, the ICDS Plan must refer, as appropriate and agreed to by the Beneficiary, to the HOME Choice Program. Beneficiaries can access HOME Choice services as long as they are not duplicative of services provided by the ICDS Plan as part of Care Management. If the HOME Choice program option is pursued by the ICDS Plan for a Beneficiary, the ICDS Plan must perform required activities to prepare and support the successful transition, such as completion of forms and collaboration with the HOME Choice transition coordinator.

2.5.3.3.5.4. HCBS Waiver Service Coordination and Operational Requirements: Waiver Service Coordination shall be considered a key component of the ICDS Plan's comprehensive Care Management model. The ICDS Plan will use a Waiver Service Coordinator who will be responsible for developing the waiver service plan with the Beneficiary; sharing the waiver service plan with the team for review and approval; coordinating the approved waiver services; assuring the

Beneficiary's health, welfare, and adequacy of service delivery; and integrating the waiver service plan into the ICP.

2.5.3.3.5.4.1. The ICDS Plan must ensure the following for Beneficiaries receiving HCBS waiver services:

2.5.3.3.5.4.1.1. A Beneficiary who is enrolled in the HCBS waiver will be afforded the opportunity to select a Waiver Service Coordinator to facilitate and manage the delivery of waiver services authorized in the waiver service plan. The ICDS Plan is required to contract with AAAs to perform Waiver Service Coordination for, at a minimum, individuals age sixty (60) and older. The ICDS Plan may perform Waiver Service Coordination as part of comprehensive Care Management and/or contract with entities that have experience working with people with disabilities, including, but not limited to centers for independent living and disability-oriented Case Management agencies, etc.

2.5.3.3.5.4.1.2. The ICDS Plan will be required to attest that Care Managers and Waiver Service Coordinators are not: related by blood or marriage to the Beneficiary or any paid caregiver; financially responsible for the Beneficiary; empowered to make financial or health related decisions on behalf of a Beneficiary; and Providers of any HCBS services.

2.5.3.3.5.4.1.3. The ICDS Plan must complete the ongoing assessment of LTSS for a Beneficiary currently receiving waiver services and the initial LTSS for a Beneficiary who presents a need (i.e., community well). Based on the LTSS assessment and other data collected as a result of the Comprehensive Assessment process, the Waiver Service Coordinator will develop a waiver service plan as described below with the Beneficiary that identifies the HCBS (amount, duration, and scope) that will promote the Beneficiary's ability to live independently and avoid residing in an institutional setting.

2.5.3.3.5.4.1.4. The ICDS Plan must allow a Beneficiary to exercise choice and control over the provision of waiver services they receive as determined

during the waiver service planning process. The ICDS Plan must also honor a Beneficiary's choice and preference for which individuals participate in the waiver service planning process. The Beneficiary will also be allowed to exercise authority over the selection and direction of certain waiver services, including the opportunity to pursue self-direction of certain waiver services as described below. Services and supports must be planned and implemented in accordance with each Beneficiary’s needs and expressed preferences.

2.5.3.3.5.4.1.5. Self-Direction: The ICDS Plan is responsible for the promotion of self-direction to Beneficiaries enrolled on the HCBS waiver and in accordance with ODM's requirements.

2.5.3.3.5.4.1.5.1. Required activities include but are not limited to: participation of all Care Managers and Waiver Service Coordinators in initial and on-going training about self-direction; inclusion of information about self-direction in the waiver handbook; development and distribution of a self-direction handbook for those Beneficiaries who express an interest; provision of orientation activities to waiver Beneficiaries pursuing self-direction opportunities; and contracting with the state-wide Financial Management Services (FMS) vendor for the provision of duties related to employer authority.

2.5.3.3.5.4.1.5.2. The ICDS Plan will be required to reimburse the FMS for administrative duties in support of self-directed services at the rate established by ODM and for self-directed services. The FMS vendor will reimburse the Provider directly for services.

2.5.3.3.5.4.2. Waiver Service Plan. The ICDS Plan must perform the following duties to support waiver service plan development, implementation, and monitoring which will be

conducted by the Waiver Service Coordinator in collaboration with the Trans-Disciplinary Care Team:

2.5.3.3.5.4.2.1. The ICDS Plan must review and approve of the waiver service plan in accordance with coverage and authorization service requirements as established at 42 C.F.R. § 438.210. After the waiver service plan is approved and services are authorized, the ICDS Plan must notify the Beneficiary or authorized representative of the approval and provide information on the services and start plan date. The ICDS Plan must provide a copy of the waiver service plan to the Beneficiary.

2.5.3.3.5.4.2.2. The ICDS Plan must assist the Beneficiary with the development of a back-up plan that provides for alternative arrangements of service delivery in the event that the responsible Provider fails or is unable to deliver them. The back-up plan will reflect both informal and formal services and will be incorporated into the Beneficiary’s ICP.

2.5.3.3.5.4.2.3. The ICDS Plan must ensure that the waiver service plan is updated with current and relevant information. The waiver service plan must be updated as appropriate based on the Beneficiary's assessed needs or when the ICDS Plan becomes aware of any relevant information that should be included in the plan (i.e., change in back up plans). Any updates to the waiver service plan must be provided to the Care Manager to ensure that applicable updates are also made to the ICP. Updates to the waiver service plan should occur simultaneous to updates to the Comprehensive Assessment and the ICP.

2.5.3.3.5.4.2.4. The ICDS Plan must ensure that the Waiver Service Coordinator is monitoring the health and welfare of the Beneficiary and the adequacy of service delivery. The Waiver Service Coordinator must perform these activities and provide the required information to the Care Manager so ICP and waiver service plan can be updated based on the monitoring activities. The ICDS Plan must monitor and assure that:

2.5.3.3.5.4.2.4.1. The Beneficiary can exercise free choice of Provider from among the ICDS Plan's panel of Providers;

2.5.3.3.5.4.2.4.2. Service delivery and outcomes specified in the waiver service plan are appropriate;

2.5.3.3.5.4.2.4.3. Delivered services meet the needs of the Beneficiary;

2.5.3.3.5.4.2.4.4. Methods are in place for prompt follow up and remediation of identified problems; and

2.5.3.3.5.4.2.4.5. Reporting outcomes of service delivery or unmet needs to the Care Manager and/or Trans-Disciplinary Care Team.

2.5.3.3.5.4.2.5. Modifications to the waiver service plan and delivery schedule must be initiated as the need or issue is identified through the monitoring process. The ICDS Plan must allow the Beneficiary to choose a remediation method to resolve identified issues, including selection of alternate Providers, negotiation with current Providers for service modifications, adding (waiver and non-waiver) services and changes in the level of involvement of the Beneficiary's informal support system. The ICDS Plan must update the waiver service plan to describe the intervention developed to address the issue, time frame for implementation, responsible parties, and timeframes to evaluate the effective of the intervention in resolved the identified problem.

2.5.3.3.5.4.2.6. The ICDS Plan must monitor and evaluate the effectiveness of services as well as the Beneficiary's satisfaction with the intervention. All waiver service planning must be integrated into the comprehensive Care Management process.

2.5.3.3.5.4.3. HCBS Operational Requirements. The ICDS Plan is required to provide all required data necessary for the efficient and appropriate operation of the HCBS waiver as approved by CMS and directed by ODM, including but not

limited to data related to the quality measures and data related to the day-to-day operations of the waiver.

2.5.3.3.5.4.4. Incident Management: The ICDS Plan must assure the health and welfare of the Beneficiaries enrolled in the HCBS waiver. The ICDS Plan is required to adhere to the following requirements:

2.5.3.3.5.4.4.1. The ICDS plan must have policies for: 1) reporting, investigating, and remediation of individual incidents; and 2) developing individual prevention plans specific to the Beneficiary. The ICDS Plan must develop and implement an incident management tracking system.

2.5.3.3.5.4.4.2. Any staff person employed with the ICDS Plan who has contact with Beneficiaries enrolled on the HCBS waiver including all Waiver Service Coordinators, are required to report incidents in accordance with applicable OAC rules, including OAC rule 5160-58-05.3 governing incident management under ODM-administered waivers. In addition, Ohio law requires certain licensed professionals to report abuse, neglect, and exploitation to law enforcement, child or adult protective service entities and county boards of developmental disabilities, as appropriate. These licensed professionals include physicians, nurses, social workers, and any other health care staff with professional licenses.

2.5.3.3.5.4.4.3. The ICDS Plan is responsible for assuring that Beneficiaries are protected from abuse, neglect, exploitation, mistreatment and other threats to their health, safety and well-being, and to quickly and appropriately report, respond to, investigate and remediate the effects of such incidents when they occur.

2.5.3.3.5.4.4.4. Upon a Beneficiary's Enrollment in the HCBS waiver, and at the time of each reassessment, the ICDS Plan shall provide the Beneficiary and his or her authorized representative with written information and education about how to report abuse, neglect, exploitation and other incidents. The ICDS Plan shall secure written confirmation of receipt of education and written materials from the Beneficiary/authorized

representative and it shall be maintained in the Beneficiary's ICP or other written record.

2.5.3.3.5.4.4.5. The ICDS Plan must maintain its own incident reporting and management system that will address certain incidents as specified by ODM. The ICDS Plan must report information regarding incidents to ODM or its designee, either through a file exchange or through direct entry and use of an ODM's incident management system. The ICDS Plan must comply with additional requirements as specified by ODM.

2.5.3.3.5.4.5. Home Modifications: The ICDS Plan must have qualified staff or must subcontract with a person/organization to complete accurate job specifications for home modifications and who can prepare those specifications to bid. This person/organization must have a minimum of seven (7) years of experience in residential architectural or construction that includes accessible design and construction.

2.5.3.3.5.4.6. Emergency Response Plan: The ICDS Plan must develop and implement as necessary, an ODM approved Emergency Response Plan (ERP), for natural disasters and other public emergencies (e.g., floods, extreme heat, power outage, extreme cold, etc.). Coordination with other appropriate systems is recommended (e.g. American Red Cross). The ICDS Plan must address the following related to the ERP:

2.5.3.3.5.4.6.1. The ICDS Plan must indicate how identification of Beneficiaries will occur who will be most at risk for harm, loss, or injury during any potential natural, technological, or man-made disaster.

2.5.3.3.5.4.6.2. The ICDS Plan must also describe how and when the ERP will be implemented. The ICDS Plan will report immediately to the CMT when the ERP has been activated.

2.5.3.3.5.4.7. Ombudsman: The Ohio Office of the State Long-term Care Ombudsman Program is statutorily authorized to advocate and investigate on behalf of Ohio's home- and community-based care and nursing facility-based recipients to safeguard due process, and serve as the early and consistent means of identifying systematic problems. Capitalizing on the

function of Ohio's Office of the State Long-Term Care Ombudsman, the State will create MyCare Ohio Ombudsman to support the objectives of Ohio's newly integrated care delivery system. The MyCare Ohio Ombudsman program will expand the State Long-Term Care Ombudsman's current accessibility to serve the needs of all beneficiaries participating in the Demonstration. The Ombudsman shall provide core ombudsman services to beneficiaries including outreach, consumer empowerment through education, complaint investigation, person-centered complaint resolution, and shall collect and report casework data to CMS on a quarterly basis. The Ombudsman shall be accessible to consumer advisory boards, and shall participate in all statewide stakeholder and oversight activities. The Ombudsman shall maintain access to and will coordinate with the CMT.

2.5.3.4. Care Management Administrative Requirements

2.5.3.4.1. Training for ICDS Plan Care Managers and Trans-Disciplinary Care Team Members and Waiver Service Coordinators

2.5.3.4.1.1. Training for ICDS Plan Care Managers and Trans-Disciplinary Care Team Members: The ICDS Plan must conduct professional training sessions on an annual basis for its Care Managers and staff who participate on the Trans-Disciplinary Care Team on the following topics: person-centered care planning processes, cultural and disability competence, communication, accessibility and accommodations, independent living and recovery, and wellness principles, Americans with Disabilities Act (ADA)/Olmstead requirements, and other topics as specified by the state.

2.5.3.4.1.2. Training for Waiver Service Coordinators:

2.5.3.4.1.2.1. The ICDS Plan must require that Waiver Service Coordinators participate in trainings during the implementation phase of ICDS. The following topics must be covered:

2.5.3.4.1.2.1.1. Federal and state laws and program requirements;

2.5.3.4.1.2.1.2. Initial contact and information and referral;

2.5.3.4.1.2.1.3. Assessment;

2.5.3.4.1.2.1.4. Eligibility;

2.5.3.4.1.2.1.5. Enrollment;

2.5.3.4.1.2.1.6. LOC;

2.5.3.4.1.2.1.7. Care Planning (goals, objectives, outcomes, and service planning);

2.5.3.4.1.2.1.8. Use of person-centered language in all communications;

2.5.3.4.1.2.1.9. Due process including grievances and appeals;

2.5.3.4.1.2.1.10. Service specifications, including process for requesting home and vehicle modifications, and adaptive and assistive equipment;

2.5.3.4.1.2.1.11. Provider Enrollment and monitoring;

2.5.3.4.1.2.1.12. Documentation requirements;

2.5.3.4.1.2.1.13. Abuse, neglect and exploitation, and all other incident reporting;

2.5.3.4.1.2.1.14. Medication management;

2.5.3.4.1.2.1.15. Risk and safety planning – identifying individual risks and the modifications or equipment necessary to maintain an individual in the home;

2.5.3.4.1.2.1.16. Individualized service planning and self-direction;

2.5.3.4.1.2.1.17. Restraints, seclusion, and restrictive interventions; and

2.5.3.4.1.2.1.18. Community resources including an overview of at least one other delivery system, such as developmental disabilities, mental health, aging, health, etc., an explanation of the resources available, and training on how to access the services.

2.5.3.4.1.2.2. Mandatory annual training for Waiver Service Coordinators must occur on the following topics:

2.5.3.4.1.2.2.1. Cultural competency/diversity training that is specific to the region and addresses the culture/diversity in that region;

2.5.3.4.1.2.2.2. Medication management;

2.5.3.4.1.2.2.3. LOC;

2.5.3.4.1.2.2.4. Provider service specifications, including process for requesting home and vehicle modifications and adaptive and assistive equipment;

2.5.3.4.1.2.2.5. Risk and safety planning – identifying individual risks and the modifications or equipment necessary to maintain a Beneficiary in the home:

2.5.3.4.1.2.2.6. Individualized service planning and self-direction;

2.5.3.4.1.2.2.7. Restraints, seclusion and restrictive interventions;

2.5.3.4.1.2.2.8. Community resources including an overview of at least one other service delivery system, such as developmental disabilities, mental health, aging, health, etc., developmental disabilities, mental health, aging, health, etc., an explanation of the resources available, and training on how to access the services;

2.5.3.4.1.2.2.9. HIPAA; and

2.5.3.4.1.2.2.10. Customer Service.

2.5.3.4.1.3. The ICDS Plan must provide written attestations to ODM that they have provided all of the required training.

2.5.3.4.2. Community Resource Guide: The ICDS Plan must identify community, social and recovery support services that are available at the county level and develop a resource guide which contains a listing of the support services agencies, services provided, hours of operation, address, contact numbers, and any applicable eligibility criteria (e.g., age limitations). The community resource guide must be kept up-to-date and made available to ICDS staff and Trans-Disciplinary Care Team members who have contact with Beneficiaries. Upon request, the community resource guide must be made available to Beneficiaries.

2.5.3.4.3. Care Management Program Evaluation: The ICDS Plan must develop and implement a strategy to routinely evaluate the effectiveness and impact of the ICDS Plan's Care Management model with regard to health outcomes, consumer satisfaction, quality of life, independent living status, functional status, hospital and emergency

department rates, preventable admissions and readmissions, medical costs, etc. The ICDS Plan must produce results for the overall program and by each stratification level. Results must be made available to ODM upon request. The ICDS Plan must use the evaluation results to make enhancements, as necessary, to the Care Management program.

2.5.3.4.4. Care Management Data Submission: The ICDS plan must submit an electronic file of Care Management data as specified by ODM. In addition the ICDS Plan must submit a description of the Care Management model, assessment tools, staffing model, care plan templates, etc., for review and approval as specified by ODM. Documentation submitted by the ICDS Plan as well as care management records are subject to a review and audit by ODM and/or the external quality review organization (EQRO).

2.5.4. Transition of Care

2.5.4.1. Transition of Care Process. The ICDS Plan must allow Beneficiaries to maintain current Providers and service levels at the time of Enrollment as described in Table 1- A below. If a Beneficiary enrolls in an ICDS plan for Medicaid benefits prior to enrolling in the demonstration, then the transition timeframe for Medicaid services begins on the beneficiary's Medicaid enrollment effective date. The timeframes for Medicaid services in Table 1-A include the Medicaid enrollment period immediately preceding enrollment in the demonstration.

2.5.4.1.1. During the transition period, change from the existing provider can only occur in the following circumstances:

2.5.4.1.1.1. Beneficiary requests a change;

2.5.4.1.1.2. The Provider chooses to discontinue providing services to an Beneficiary as currently allowed by Medicare or Medicaid; or

2.5.4.1.1.3. The ICDS Plan, CMS, or the ODM identified Provider performance issues that affect a Beneficiary's health and welfare.

2.5.4.2. The ICDS Plan must notify Providers and consumers prior to the end of a transition period if a change in Provider and/or service delivery is planned.

Table 1-A: ICDS Plan Transition Requirements at Enrollment

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
Physician	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others
DME	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity
Scheduled Surgeries	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Chemotherapy/ Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Dialysis Treatment	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.
Vision and Dental	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
Medicaid Home Health and PDN	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless: A significant change occurs as defined in OAC 5160-45-01; or Individuals expresses a desire to self-direct services; or after 365 days.	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A
Assisted Living Waiver Service			Provider maintained at current rate for the life of Demonstration.	
Medicaid Nursing Facility Services			Provider maintained at current Medicaid rate for the life of Demonstration.	
Waiver Services-Direct Care Personal Care Waiver Nursing Home Care Attendant Choice Home Care Attendant Out of Home Respite Enhanced Community	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless: A significant change occurs as	N/A	N/A	N/A

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
Living Adult Day Health Services Social Work Counseling Independent Living Assistance	defined in OAC 5160-45-01 ; or Individuals expresses a desire to self-direct services; or after 365 days.			
Waiver Services-All other	Maintain service at current level for 365 days and existing service provider at existing rate for 90 days. Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.	N/A	N/A	N/A
Medicaid Community Behavioral Health Organizations (Provider types 84 & 95).	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.

2.6. **Provider Network**

2.6.1. General

2.6.1.1. The ICDS Plan must demonstrate as required by CMS and ODM that it has an adequate Provider Network sufficient in number, mix, and geographic distribution, to ensure adequate access to medical, behavioral health, pharmacy, and LTSS Providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access.

2.6.1.2. The ICDS Plan must maintain a Provider Network sufficient to provide all Beneficiaries with access to the full range of Covered Services, including behavioral health services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A). The ICDS Plan must notify the CMT of any significant Provider Network changes in accordance with requirements established in OAC 5160-58-01.1 and 5160-26-05, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change. In addition, the ICDS Plan must notify the CMT when there are other significant changes in the ICS Plan's operations that would affect capacity and services, including changes in services, benefits, geographic service area or payments, or enrollment of a new population.

2.6.1.3. The ICDS Plan shall establish, maintain and monitor their provider network, sufficient to provide adequate access to all Covered Services under the Contract including the appropriate range of preventive, primary care and specialty service, taking into consideration:

2.6.1.3.1. The anticipated number of Beneficiaries;

2.6.1.3.2. The expected utilization of services, in light of the characteristics and health care needs of the ICDS Plan's Beneficiaries;

2.6.1.3.3. The number and types of Providers required to furnish the Covered Services;

2.6.1.3.4. The number of network providers who are not accepting new Medicaid patients; and

2.6.1.3.5. The geographic location of Providers and Beneficiaries, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Beneficiaries with disabilities.

2.6.1.4. The CMT will monitor the ICDS Plan's Beneficiaries' access to services through survey, utilization, and complaints data to assess ICDS Plan networks and require corrective action as necessary. The CMT will monitor access to care and the prevalence of unmet needs indicated through Beneficiary

assessments and, based on findings may require that the ICDS Plans initiate further network expansion over the course of the Contract.

2.6.1.5. The ICDS plan must submit an electronic file to ODM or its designee and update as required to maintain the ICDS Plan's complete Provider panel.

2.6.1.6. The ICDS Plan must comply with the requirements specified in 42 C.F.R. §§ 422.504, 423.505, 438.214, which includes written policies and procedures related to selection and retention of Providers, credentialing and recredentialing requirements, and nondiscrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.6.1.7. The ICDS Plan 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.

2.6.1.8. The ICDS Plan must make reasonable efforts to contact out-of-network Providers, including Providers and prescribers that are providing services to Beneficiaries during the initial transition of care period documented in Table 1-A, to inform them that the transition period will end on a specified date, and provide them with information on becoming a credentialed network Provider, if the ICDS Plan is accepting new applications for that provider type.

2.6.1.9. The ICDS Plan must also offer single-case out-of-network agreements to Providers to provide services to the Beneficiary until a qualified network Provider is available.

2.6.1.10. The ICDS Plan shall ensure that its Provider Network is responsive to the linguistic, cultural, ethnic, racial, religious, age, gender, and other unique needs of any minority, homeless person, disabled individuals, or other special population served by the ICDS Plan, including the capacity to communicate with Beneficiaries in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or blind.

2.6.1.11. The ICDS Plan shall educate Providers through a variety of means including, but not limited to, Provider Alerts or similar written issuances about their legal obligations under Ohio and federal law to communicate with individuals with limited English proficiency, including the provision of interpreter services, and the resources available to help Providers comply with those obligations. All such written communications shall be subject to review at ODM's and CMS' request.

2.6.1.12. The ICDS Plan shall ensure that multilingual network Providers and, to the extent that such capacity exists within the ICDS Plan's Service Area, all network

Providers, understand and comply with their obligations under Ohio or federal law to assist Beneficiaries with skilled medical interpreters and the resources that are available to assist network Providers to meet these obligations.

2.6.1.13. The ICDS Plan shall ensure that network Providers and interpreters or translators are available for those who are deaf or hearing-impaired within the ICDS Plan's Service Area.

2.6.1.14. At the Beneficiary's request, the ICDS plan shall provide for a second opinion from a qualified health care professional within the Provider Network, or arrange for the Beneficiary to obtain one outside the Provider Network, at no cost to the Beneficiary.

2.6.1.15. The ICDS Plan shall ensure that the Provider Network provides female Beneficiaries with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This shall include contracting with, and offering to female Beneficiaries, women's health specialists as PCPs.

2.6.1.16. For Beneficiaries with special health care needs or determined to need a course of treatment or regular care monitoring, the ICDS Plan must have a mechanism in place to allow Beneficiaries direct access a specialist as appropriate for the Beneficiary's condition and identified needs.

2.7. Provider Qualifications and Performance

2.7.1. Primary Care Qualifications: Each Beneficiary will choose or be assigned to a PCP. The PCP must be one of the following:

2.7.1.1. A Primary Care Physician that is:

2.7.1.1.1. Licensed by the State of Ohio or the State in which the Provider practices;

2.7.1.1.2. Board-certified, when required by Medicare or Medicaid, in Family Practice, Internal Medicine, General Practice, OB/GYN, Pediatrics or Geriatrics; or

2.7.1.2. A Physician Extender who is:

2.7.1.2.1. A Registered Nurse Practitioner or advanced practice nurse as defined in Section 4723.43 of the ORC, or advanced practice nurse group practice within an acceptable specialty, contracting with an ICDS Plan to provide services as specified in OAC 5160-58-01.1(B) and 5160:3-26-03.1 of the OAC; or

2.7.1.2.2. Physician Assistant who is licensed by the Board of Registration of Physician Assistants to practice in the State of Ohio or the State in which the Physician Assistant practices; and

2.7.2. Each physician or physician extender shall be in good standing with the Medicare and/or Medicaid programs, as applicable.

2.7.3. Subcontracting Requirements

2.7.3.1. The ICDS Plan remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the ICDS Plan subcontracts for performance of any Contract responsibility. The ICDS plan shall require each First Tier, Downstream, or Related Entity to meet all terms and requirements of the Contract that are applicable to such First Tier, Downstream or Related Entity. No subcontract will operate to relieve the ICDS Plan of its legal responsibilities under the Contract.

2.7.3.2. The ICDS Plan is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and Ohio financial and program reporting requirements as the ICDS Plan. The ICDS Plan is required to evaluate any potential First Tier, Downstream or Related Entity prior to delegation, pursuant to 42 C.F.R. § 438.20. Additional information about subcontracting requirements is contained in Appendix C.

2.7.3.3. The ICDS Plan must establish and maintain contracts and other written agreements between the ICDS Plan and First Tier, Downstream and Related Entities for any program requirement not delivered directly by the ICDS Plan or its employees.

2.7.3.4. Unless otherwise specified in this Contract or OAC rule 5160-58-01.1 and 5160-26-05, the ICDS Plan is required to enter into fully-executed subcontracts with their Providers and should contract only with qualified or licensed Providers who continually meet federal and state requirements, as applicable, and the qualifications contained in Appendix C and the State Medicaid Combined Services Subcontract Addendum. (see Appendix I)

2.7.4. The ICDS Plan will ensure network provider compliance with timely access requirements, pursuant to 42 C.F.R. § 438.206(c)(1).

2.7.5. ICDS Plan shall ensure that all First Tier, Downstream and Related Entities receive the following procedures and timeframes at the time of entering into a contract or arrangement with the ICDS Plan:

2.7.5.1. The Beneficiary's right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;

2.7.5.2. The Beneficiary's right to file grievances and appeals and their requirements and timeframes for filing;

2.7.5.3. The availability of assistance in filing;

2.7.5.4. The toll-free numbers to file oral grievances and appeals;

2.7.5.5. The Beneficiary's right to request continuation of benefits during an appeal or State Fair Hearing filing and, if the MCO or PIHP's action is upheld in a hearing, the Beneficiary may be liable for the cost of any continued benefits; and

2.7.5.6. Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

2.7.6. Non-Payment and Reporting of Provider Preventable Conditions

2.7.6.1. The ICDS Plan agrees to take such action as is necessary in order for ODM to comply with and implement all federal and state laws, regulations, policy guidance, and State policies and procedures relating to the identification, reporting, and non-payment of Provider Preventable conditions, including 42 U.S.C. § 1396b-1 and regulations promulgated thereunder.

2.7.6.2. As a condition of payment, the ICDS Plan shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to, 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.6(f)(2), and 42 C.F.R. § 447.26, as well as ODM procedures and guidance on Provider Preventable Conditions. The ICDS Plan's policies and procedures shall also be consistent with the following:

2.7.6.2.1. The ICDS Plan shall not pay a Provider for a Provider Preventable Condition.

2.7.6.2.2. The ICDS Plan shall require, as a condition of payment from the ICDS Plan, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the ICDS Plan and/or ODM.

2.7.6.2.3. The ICDS Plan shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider Preventable Condition for a particular Beneficiary existed prior to the Provider's initiation of treatment for that Beneficiary.

2.7.6.2.4. The ICDS Plan may limit reductions in Provider payments to the extent that the following apply:

2.7.6.2.4.1. The identified Provider Preventable Condition would otherwise result in an increase in payment.

2.7.6.2.4.2. The ICDS Plan can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition.

2.7.6.2.5. The ICDS Plan shall ensure that its non-payment for Provider Preventable Conditions does not prevent Beneficiary access to services.

2.7.7. Provider Manual

2.7.7.1. The ICDS plan must provide the following written information to their network Providers:

2.7.7.1.1. The ICDS Plan's Grievance, Appeal and state fair hearing procedures and time frames, including:

2.7.7.1.1.1. The Beneficiary’s right to file Grievances and Appeals and the requirements and time frames for filing;

2.7.7.1.1.2. The ICDS Plan's toll-free telephone number to file oral Grievances and Appeals;

2.7.7.1.1.3. The Beneficiary’s right to a state fair hearing, the requirements and time frames for requesting a hearing, and representation rules at a hearing;

2.7.7.1.1.4. The availability of assistance from the ICDS Plan in filing any of these actions;

2.7.7.1.1.5. The Beneficiary’s right to request continuation of benefits during an Appeal or a state hearing and specification that at the discretion of ODM the Beneficiary may be liable for the cost of any such continued benefits; and

2.7.7.1.1.6. The Provider's rights to participate in these processes on behalf of the Provider's patients and to challenge the failure of the ICDS Plan to cover a specific service.

2.7.7.1.2. The ICDS Plan's requirements regarding the submission and processing of Prior Authorization requests including:

2.7.7.1.2.1. A list of the benefits, if any, that require Prior Authorization approval from the ICDS Plan;

2.7.7.1.2.2. The process and format to be used in submitting such requests;

2.7.7.1.2.3. The time frames in which the ICDS Plan must respond to such requests, which may not be longer than set forth in 42 C.F.R. § 438.210;

2.7.7.1.2.4. How the Provider will be notified of the ICDS Plan's decision regarding such requests; and

2.7.7.1.2.5. The procedures to be followed in appealing the ICDS Plan's denial of a Prior Authorization request.

2.7.7.1.3. The ICDS Plan's requirements regarding the submission and processing of requests for specialist referrals including:

2.7.7.1.3.1. A list of the Provider types, if any, that require Prior Authorization approval from the ICDS Plan;

2.7.7.1.3.2. The process and format to be used in submitting such requests;

2.7.7.1.3.3. How the Provider will be notified of the ICDS Plan's decision regarding such requests; and

2.7.7.1.3.4. The procedures to be followed in appealing the ICDS plan's denial of such requests.

2.7.7.1.4. The ICDS Plan's documentation, legibility, confidentiality, maintenance and access standards for Beneficiary's medical records; including a Beneficiary's right to amend or correct his or her medical record as specified in 45 C.F.R. Part 164.

2.7.7.1.5. The ICDS Plan's process and requirements for the submission of claims and the Appeal of denied claims.

2.7.7.1.6. The ICDS Plan's process and standards for the recredentialing of Providers.

2.7.7.1.7. The ICDS Plan's policies and procedures regarding what action the ICDS Plan may take in response to occurrences of undelivered, inappropriate or substandard health care services, including the reporting of serious deficiencies to the appropriate authorities.

2.7.7.1.8. A description of the ICDS Plan's care coordination and Care Management programs, and the role of the Provider in those programs, including:

2.7.7.1.8.1. The ICDS Plan's criteria for determining the level of care management from which a Beneficiary might benefit;

2.7.7.1.8.2. The Provider's responsibility in identifying Beneficiaries who may meet the ICDS Plan's Care Management criteria; and

2.7.7.1.8.3. The process for the Provider to follow in notifying the ICDS Plan when such Beneficiaries are identified.

2.7.7.1.9. The ICDS Plan's requirements and expectations for PCPs, including triage requirements.

2.7.7.1.10. The mutually agreed upon policies and procedures that explain the Provider's obligation to provide oral translation, oral interpretation, and sign language services to the ICDS Plan's Beneficiaries including:

2.7.7.1.10.1. The Provider's responsibility to identify those Beneficiaries who may require such assistance;

2.7.7.1.10.2. The process the provider is to follow in arranging for such services to be provided;

2.7.7.1.10.3. Information that Beneficiaries will not be liable for the costs of such services; and

2.7.7.1.10.4. Specification of whether the ICDS Plan or the Provider will be financially responsible for the costs of providing these services.

2.7.7.1.11. The procedures that Providers are to follow in notifying the ICDS Plan of changes in their practice, including at a minimum:

2.7.7.1.11.1. Address and phone numbers;

2.7.7.1.11.2. Providers included in the practice;

2.7.7.1.11.3. Acceptance of new patients; and

2.7.7.1.11.4. Standard office hours.

2.7.7.1.12. Specification of what service utilization and Provider performance data the ICDS Plan will make available to Providers.

2.7.7.1.13. Specification of the Healthchek components to be provided to eligible Beneficiaries as specified in Chapter 5160-14 of the OAC.

2.7.7.1.14. The ICDS Plan must adopt practice guidelines and provide written copies to all affected Providers. These guidelines must:

2.7.7.1.14.1. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

2.7.7.1.14.2. Consider the needs of the ICDS Plan’s Beneficiaries;

2.7.7.1.14.3. Be adopted in consultation with contracting health care professionals; and

2.7.7.1.14.4. Be reviewed and updated periodically, as appropriate.

2.7.7.1.15. The ICDS Plan must have staff specifically responsible for resolving individual Provider issues, including, but not limited to, problems with claims payment, Prior Authorizations and referrals. The ICDS Plan must provide written information to their contracting providers detailing how to contact these designated staff.

2.7.8. Network Management -- General Requirements

2.7.8.1. The ICDS Plan shall develop and implement a strategy to manage the Provider Network with a focus on access to services for Beneficiaries, quality, consistent practice patterns, Independent Living Philosophy, Cultural Competence, and the integration and cost effectiveness. The management strategy shall address all Providers.

2.7.8.2. In establishing and maintaining their Provider panel, the ICDS Plan must consider the following:

2.7.8.2.1. The anticipated membership.

2.7.8.2.2. The expected utilization of services, taking into consideration the characteristics and health care needs of specific populations represented in the ICDS Plan.

2.7.8.2.3. The number and types (in terms of training, experience, and specialization) of panel Providers required to deliver the Covered Services.

2.7.8.2.4. The geographic location of panel Providers and Beneficiaries, considering distance, travel time, the means of transportation ordinarily used by Beneficiaries, and whether the location provides physical access for Beneficiaries with disabilities.

2.7.8.2.5. The ICDS Plan must adequately and timely cover services to an out-of-network Provider if the ICDS Plan's contracted Provider panel is unable to provide the services covered under the ICDS Plan's Provider agreement. The ICDS Plan must cover the out-of-network services for as long as the ICDS Plan network is unable to provide the services. ICDS Plans must coordinate with the out-of-network provider with respect to payment and ensure that the provider agrees with the applicable requirements.

2.7.9. Proximity Access Requirements

2.7.9.1. The ICDS Plan must demonstrate annually that its Provider Network meets the stricter of the following standards:

2.7.9.1.1. For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/ index.html);

2.7.9.1.2. For Medicare pharmacy providers, time, distance and minimum number as required in and 42 C.F.R. § 423.120

2.7.9.2. Within the following State Specific Standards:

2.7.9.2.1. LTSS Providers:

2.7.9.2.1.1. At least two (2) community LTSS Providers in each region for the following services: enhanced community living, homemaker, waiver transportation, nutritional consultation, social work counseling, out of home respite, home medical equipment and supplemental adaptive and assistive devices, independent living assistance and community transition.

2.7.9.2.1.2. At least one (1) community LTSS Provider in each region for the following services: pest control, home delivered meals, emergency response, home modifications maintenance and repairs, and chore services.

2.7.9.2.2. Adult Day Health/Assisted Living: At least one (1) adult day health and one (1) assisted living provider within thirty (30) miles of each zip code within the region.

2.7.9.2.3. LTSS Agency Providers: At least two (2) community LTSS Agency Providers in each region for the following services: personal care and waiver nursing.

2.7.9.2.4. In some situations an LTSS Independent Provider's home office location is in a centralized area of the state yet those Providers serve Beneficiaries in a region that is not the home address (e.g.waiver transportation, home delivered meals, home medical equipment and supplemental adaptive and assistive device, pest control, emergency response, home modifications maintenance and repairs, and chore services). If the ICDS Plan chooses to document the same Provider in more than one region to meet minimum requirements, they must submit the contracts for these Providers for ODM review to determine whether the contract documents the provision of services to all counties in the regions requested.

2.7.9.2.5. Vision Care Providers – The ICDS Plan must contract with at least the minimum number of ophthalmologists as required by CMS and

ODM and optometrists as required by ODM for each specified county/region, all of whom must maintain a full-time practice at a site(s) located in the specified county/region to count toward minimum panel requirements. All ODM-approved optometrists must regularly perform routine eye exams. If optical dispensing is not sufficiently available in a region through the ICDS Plan's contracting ophthalmologists/optometrists, the ICDS Plan must separately contract with an adequate number of optical dispensers located in the region.

2.7.9.2.6. Dental Care Providers – The ICDS Plan must contract with at least the minimum number of dentists as required by ODM.

2.7.9.2.7. FQHCs/Rural Health Clinics (RHCs) – The ICDS Plan is required to ensure Beneficiary access to any FQHCs/RHCs, regardless of contracting status. Contracting FQHC/RHC providers must be submitted for ODM review via the MCPN process, or other designated process. Even if no FQHC/RHC is available within the region, the ICDS Plan must have mechanisms in place to ensure coverage for FQHC/RHC services in the event that a Beneficiary accesses these services outside of the region.

2.7.9.2.7.1. The ICDS Plan must offer FQHCs reimbursement pursuant to the following:

2.7.9.2.7.1.1. The ICDS Plan shall ensure that payments to FQHCs for services to Beneficiaries are no less than the sum of:

2.7.9.2.7.1.1.1. The level and amount of payment that the ICDS Plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC, and

2.7.9.2.7.1.1.2. The amount that Ohio Medicaid would have paid in cost sharing if the Beneficiary were in FFS.

2.7.9.2.7.2. Additionally, the ICDS Plan must:

2.7.9.2.7.2.1. Provide FQHCs/RHCs the ICDS Plan's Medicaid provider number(s) for each region to enable FQHC/RHC providers to bill for the ODM wraparound payment for dental and vision services not covered by Medicare.

2.7.9.2.7.2.2. Educate their staff and Providers on the need to assure Beneficiary access to FQHC/RHC services.

2.7.9.2.8. Qualified Family Planning Providers (QFPPs) - All ICDS Plan Beneficiaries must be permitted to self-refer for services and supplies allowed under Title X of the Public Health Services Act (Title X services)

provided by a QFPP. The ICDS Plan must reimburse all Medically Necessary Medicaid-covered Title X services provided to eligible Beneficiaries by a QFPP (including on-site pharmacy and diagnostic services) on a Beneficiary 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.

2.7.9.2.8.1. The ICDS Plan 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 Beneficiary's PCP and/or ICDS Plan.

2.7.10. Behavioral Health Providers – The ICDS Plan must assure Beneficiary's access to all Medicaid-covered behavioral health services as specified in Appendix A. Provider Credentialing, Recredentialing, and Board Certification

2.7.10.1. The ICDS Plan must adhere to managed care standards at 42 C.F.R. § 438.214 and 42 C.F.R. § 422.204, and must be accredited by NCQA and follow NCQA procedural requirements for credentialing and re-credentialing.

2.8. Beneficiary Access to Services

2.8.1. General: The ICDS Plan must provide services to Beneficiaries as follows:

2.8.1.1. Authorize, arrange, coordinate and provide to Beneficiaries timely access to all Medically Necessary Covered Services as specified in Section 2.4 and Appendix A, in accordance with the requirements of the Contract and consistent with 42 C.F.R. § 438.206(c);

2.8.1.2. Offer adequate choice and availability of primary, specialty, acute care, behavioral health and LTSS Providers that meet CMS and the ODM standards as provided in Section 2.7.6, Proximity Access Standards.

2.8.1.3. Reasonably accommodate persons and shall ensure that the programs and services are as accessible (including physical and geographic access) to a Beneficiary with disabilities as they are to an individual without disabilities. The ICDS Plan and its Network Providers must comply with the ADA (28 C.F.R. § 35.130) and § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Beneficiaries. The ICDS Plan shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and

programmatic barriers do not inhibit Beneficiaries with disabilities from obtaining all Covered Services from the ICDS Plan by:

2.8.1.3.1. Providing flexibility in scheduling to accommodate the needs of the Beneficiaries;

2.8.1.3.2. Providing interpreters or translators for Beneficiaries who are deaf and hard of hearing and those who do not speak English;

2.8.1.3.3. Providing large print (at least 16-point font) versions of all written materials to Beneficiaries with visual impairments;

2.8.1.3.4. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.8.1.3.5. Reading notices and other written materials to individuals upon request;

2.8.1.3.6. Assisting Beneficiaries in filling out forms over the telephone;

2.8.1.3.7. Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;

2.8.1.3.8. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and

2.8.1.3.9. Individualized assistance.

2.8.1.4. The ICDS Plan must identify to ODM the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title.

2.8.1.4.1. The ICDS Plan must also establish and execute a work plan to achieve and maintain ADA compliance.

2.8.1.5. If the ICDS Plan's network is unable to provide necessary medical services covered under the Contract to a particular Beneficiary, the ICDS Plan must adequately and timely cover these services out of network for the Beneficiary, for as long as the ICDS Plan is unable to provide them through a network Provider. The ICDS Plan must ensure that the Provider agrees to accept the ICDS plan's payment as payment in full.

2.8.1.6. When a PCP is terminated from the ICDS Plan's network or leaves the network for any reason, the ICDS Plan must make a good faith effort to give written notification of termination of such Provider, within fifteen (15) days after receipt or issuance of the termination notice, to each Beneficiary who received his or her care from, or was seen on a regular basis by, the terminated PCP.

2.8.2. Services Not Subject to Prior Approval

2.8.2.1. The ICDS Plan will assure coverage of Emergency Medical Conditions and Urgent Care services. The ICDS Plan must not require prior approval for the following services:

2.8.2.1.1. Any services for Emergency Medical Conditions;

2.8.2.1.2. Urgent Care sought outside of the Service Area;

2.8.2.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical Provider is unavailable or inaccessible;

2.8.2.1.4. Family planning services; and

2.8.2.1.5. Out-of-area renal dialysis services.

2.8.3. Authorization of Services

2.8.4. In accordance with 42 C.F.R. § 438.210, the ICDS Plan shall authorize services as follows:

2.8.4.1. For the processing of requests for initial and continuing authorizations of Covered Services, the ICDS Plan shall:

2.8.4.1.1. Have in place and follow written policies and procedures;

2.8.4.1.2. Have in place procedures to allow Beneficiaries to initiate requests for provision of services;

2.8.4.1.3. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and

2.8.4.1.4. Consult with the requesting Provider when appropriate.

2.8.4.2. The ICDS Plan shall ensure that a physician and a behavioral health Provider are available as necessary to achieve twenty-four (24) hours a day access to authorization of Medically Necessary services and to coordinate transfer of stabilized Beneficiaries from the emergency department, if necessary. The ICDS Plan's Medical Necessity guidelines must, at a minimum, be consistent with Medicare standards for acute services and prescription drugs and Medicaid standards for Medicaid services not covered by Medicare. Guidelines for integrated services must provide for review, authorization and payment using both Medicare and Medicaid criteria, in that order.

2.8.4.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made

by a health care professional who has appropriate clinical expertise in treating the Beneficiary's medical condition, performing the procedure, or providing the treatment. The ICDS Plan shall assure that all behavioral health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). ICDS Plan must comply with the requirements for demonstrating parity for quantitative treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

2.8.4.4. The ICDS Plan must notify the requesting Provider, either orally or in writing, and give the Beneficiary written notice of any decision by the ICDS Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Section 5.1, and must:

2.8.4.4.1. Be produced in a manner, format, and language that can be easily understood;

2.8.4.4.2. Be made available in Prevalent Languages, upon request; and

2.8.4.4.3. Include information, in prevalent languages about how to request translation services and alternative formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency.

2.8.4.5. The ICDS Plan must make authorization decisions in the following timeframes:

2.8.4.5.1. For standard authorization decisions, provide notice as expeditiously as the Beneficiary's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension, and notice to the beneficiary pursuant to 42 C.F.R. § 438.404(c)(4) not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.8.4.5.1.1. The Beneficiary or the Provider requests an extension, or

2.8.4.5.1.2. The ICDS Plan can justify (to the satisfaction of ODM and/or CMS upon request) that:

2.8.4.5.1.2.1. The extension is in the Beneficiary's interest; and

2.8.4.5.1.2.2. There is a need for additional information where:

2.8.4.5.1.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.8.4.5.1.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.8.4.5.2. For expedited service authorization decisions, where the Provider indicates and the ICDS Plan determines that following the standard timeframe in Section 2.8.4.5.1 above could seriously jeopardize the Beneficiary's life or health or ability to attain, maintain, or regain maximum function, the ICDS Plan must make a decision and provide notice as expeditiously as the Beneficiary's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.8.4.5.2.1. The Beneficiary or the Provider requests an extension; or

2.8.4.5.2.2. The ICDS Plan can justify (to ODM and/or CMS upon request) that:

2.8.4.5.2.2.1. The extension is in the Beneficiary's interest; and

2.8.4.5.2.2.2. There is a need for additional information where:

2.8.4.5.2.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.8.4.5.2.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.8.4.5.3. In accordance with 42 C.F.R. §§ 438.6(h), 438.210, and 422.208, compensation to individuals or entities that conduct Utilization Management activities for the ICDS Plan must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Beneficiary.

2.8.4.6. ICDS Plan shall submit electronic documentation to ODM of organization determinations for Medicare and Medicaid services that are denied, in whole or in part, in accordance with specifications provided by ODM or its designee.

2.8.5. Availability of Services

2.8.5.1. Access to Services for Emergency Conditions and Urgent Care. The ICDS Plan's Provider Network must ensure access to twenty-four (24) hour Emergency Services for all Beneficiaries, whether they reside in institutions or in the community in accordance with 42 C.F.R. § 438.114. ICDS Plan shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the ICDS Plan.

2.8.5.1.1. Emergency Medical Treatment and Labor Act (EMTALA): CMS and ODM expect the ICDS Plan and Providers to comply with EMTALA, including the requirements for qualified hospital medical personnel to provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b); and, as applicable, to provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

2.8.5.1.2. The ICDS plan must take all reasonable steps to assure that a Beneficiary who has an Emergency Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The attending emergency physician, or the Provider actually treating the Beneficiary, is responsible for determining when the Beneficiary is sufficiently stabilized for transfer or discharge, and that determination is binding on the ICDS Plan as responsible for coverage and payment.

2.8.5.1.3. The ICDS Plan shall cover Emergency Services provided to Beneficiaries who are temporarily away from their residence and outside the Service Area to the extent that the Beneficiaries would be entitled to the Emergency Services if they still were within the Service Area.

2.8.5.1.4. The ICDS Plan shall not deny payment for treatment for an Emergency Medical Condition, pursuant to 42 C.F.R § 438.114.

2.8.5.1.5. The ICDS Plan shall not deny payment for treatment of an Emergency Medical Condition if a representative of the ICDS Plan instructed the Beneficiary to seek Emergency Services.

2.8.5.1.6. The ICDS Plan shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms, pursuant to 42 C.F.R. § 438.114(d).

2.8.5.1.7. The ICDS Plan shall require providers to notify the Beneficiary's PCP of a Beneficiary's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

2.8.5.1.8. A Beneficiary who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition.

2.8.5.1.9. The attending emergency physician, or the provider actually treating the Beneficiary, is responsible for determining if the Beneficiary's Emergency Medical Condition has been stabilized and the Beneficiary may be transferred or discharged, as applicable. The ICDS plan shall cover and pay for post-stabilization Care Services in accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c).

2.8.5.2. Post-Stabilization Services. The ICDS Plan shall cover and pay for Post-Stabilization Care Services in accordance with 42 C.F.R. § 438.114(e), and 42 C.F.R. § 422.113(c).

2.8.5.2.1. The ICDS Plan shall cover Post-Stabilization Services provided by Providers in the following situations:

2.8.5.2.1.1. The ICDS Plan authorized such services;

2.8.5.2.1.2. Such services were administered to maintain the Beneficiary's stabilized condition within one (1) hour after a request to the ICDS Plan for authorization of further Post-Stabilization Services; or

2.8.5.2.1.3. The ICDS Plan fails to respond to a request to authorize further Post-Stabilization Services within one (1) hour, the ICDS Plan could not be contacted, or the ICDS Plan and the treating Provider cannot reach an agreement concerning the Beneficiary's care, in which case the treating Provider must be permitted to continue the care until resolution is reached.

2.8.5.3. The ICDS plan must ensure that network Providers offer hours of operation that are no less than the hours of operation offered to commercial Beneficiaries or comparable to Medicaid fee-for-service, if the Provider serves only Medicaid Beneficiaries, and that network Providers make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary.

2.9. Beneficiary Services

2.9.1. Beneficiary Service Representatives (BSRs)

2.9.1.1. The ICDS Plan must employ BSRs trained to answer Beneficiary inquiries and concerns from Beneficiaries and prospective Beneficiaries, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.9.1.1.1. Be trained to answer inquiries and concerns from Beneficiaries and prospective Beneficiaries;

2.9.1.1.2. Be trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats;

2.9.1.1.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Beneficiaries in their primary language, including American Sign Language (ASL), or through an alternative language device or telephone translation service;

2.9.1.1.4. Inform callers that interpreter services are available and are free.

2.9.1.1.5. Be knowledgeable about Ohio Medicaid, Medicare, and the terms of the Contract, including the Covered Services listed in Appendix A;

2.9.1.1.6. Be able to respond to requests for information from beneficiaries regarding how to request a service, or the status of an existing Prior Authorization request/Coverage Determination request.

2.9.1.1.7. Be available to Beneficiaries to discuss and provide assistance with resolving Beneficiary Grievances and Appeals;

2.9.1.1.8. Have access to the ICDS Plan's Beneficiary database and an electronic Provider directory;

2.9.1.1.9. Make oral interpretation services available free-of-charge to Beneficiaries in all non-English languages spoken by Beneficiaries, including ASL;

2.9.1.1.10. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for deaf and hard of hearing Beneficiaries;

2.9.1.1.11. Demonstrate sensitivity to culture, including disability culture and the independent living philosophy;

2.9.1.1.12. Provide assistance to Beneficiaries with cognitive impairments; for example, provide written materials in simple, clear language, and individualized guidance from BSRs to ensure materials are understood;

2.9.1.1.13. Provide reasonable accommodations needed to assure effective communication and provide Beneficiaries with a means to identify their disability to the ICDS Plan;

2.9.1.1.14. Maintain employment standards and requirements (e.g., education, training, and experience) for Beneficiary services department staff and provide a sufficient number of staff to meet defined performance objectives; and

2.9.1.1.15. Ensure that BSRs make available to Beneficiaries and prospective Beneficiaries, upon request, information concerning the following:

2.9.1.1.15.1. The identity, locations, qualifications, and availability of Providers;

2.9.1.1.15.2. Beneficiaries' rights and responsibilities;

2.9.1.1.15.3. The procedures available to a Beneficiary and Provider(s) to Appeal any Adverse Actions (denial, suspension, reduction or terminations of authorized services);

2.9.1.1.15.4. How to access oral interpretation services and written materials in Prevalent Languages and alternative formats;

2.9.1.1.15.5. Information on all Covered Services and other available services or resources whether any service may be obtained directly or through referral or Prior Authorization;

2.9.1.1.15.6. The procedures for a Beneficiary to change plans or to Opt Out of the Demonstration; and

2.9.1.1.15.7. Additional information that may be required by Beneficiaries and Potential Beneficiaries to understand the requirements and benefits of the ICDS Plan.

2.9.2. Beneficiary Service Telephone Responsiveness

2.9.2.1. The ICDS Plan must operate a call center during normal business hours, and never less than from 8:00 a.m. to 8:00 p.m. (EST), seven (7) days-a-week, consistent with the required Marketing Guidelines.

2.9.2.1.1. BSRs must be available Monday through Friday, at least from 8:00 a.m. to 8:00 p.m. (EST). The ICDS Plan may use alternative call center technologies on Saturdays, Sundays, and federal holidays.

2.9.2.1.2. A toll-free TTY number or state relay service must be provided.

2.9.2.2. Call Center Performance

2.9.2.2.1. The ICDS Plan BSRs must answer eighty percent (80%) of all Beneficiary telephone calls within 30 seconds or less.

2.9.2.2.2. The ICDS Plan must limit the average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting, and before reaching a live person.

2.9.2.2.3. The ICDS Plan must limit the disconnect rate of all incoming calls to five percent (5%) percent.

2.9.2.2.4. The ICDS Plan must have a process to measure the time from which the telephone is answered to the point at which a Beneficiary reaches a BSR capable of responding to the Beneficiary's question in a manner that is sensitive to the Beneficiary's language and cultural needs.

2.9.3. Medical Advice

2.9.3.1. The ICDS Plan must provide access to medical advice and direction through a centralized twenty-four-hour, seven day (24/7), toll-free call-in system, available nationwide, pursuant to OAC 5160-58-01.1(B) and 5160-26-03.1(A)(6). The 24/7 call-in system must be staffed by appropriately trained medical personnel.

2.9.3.2. For the purposes of meeting this requirement to provide medical advice via call-in system, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs).

2.9.4. Prior Authorization, Coverage Determinations and Appeals Call Center Requirements

2.9.4.1. The ICDS Plan must operate toll-free callcenter(s) with live customer service representatives available to respond to Providers or Beneficiaries for information related to requests for coverage under Medicare or Medicaid, and Medicare and Medicaid Appeals (including requests for Medicare exceptions and Prior Authorizations). The ICDS Plan is required to provide Beneficiaries and their representatives or Providers immediate access to make requests for Medicare and Medicaid covered benefits and services, including Medicare

Coverage Determinations and redeterminations, via its toll-free call center. The call center must operate during normal business hours and never less than from 8:00 a.m. to 6:00 p.m. ET, Monday through Friday. The ICDS Plan must accept requests for Medicare or Medicaid coverage, including Medicare Coverage Determinations /Redeterminations, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours. Providers and Beneficiaries must be allowed to submit Prior Authorization requests electronically. Voicemail may be used outside of normal business hours provided the message:

2.9.4.1.1. Indicates that the mailbox is secure;

2.9.4.1.2. Lists the information that must be provided so the case can be worked (e.g., Provider identification, Beneficiary identification, type of request (Coverage Determination or Appeal), physician support for an exception request, and whether the Beneficiary or Provider is making an expedited or standard request);

2.9.4.1.3. For Coverage Determination calls (including exceptions requests), related to Part D or Medicaid covered drugs, articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.9.4.1.4. For Appeals calls related to Part D or Medicaid covered drugs, information should articulate the process information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Appeal requests.

2.9.5. Beneficiary Participation on Governing and Advisory Committee

2.9.5.1. The ICDS Plan shall obtain Beneficiary and community input on issues of program management and Beneficiary care through a range of approaches.

2.9.5.2. The ICDS Plan must establish at least one Beneficiary advisory committee per region that meets quarterly and must develop a process for that committee to provide input to the governing board.

2.9.5.3. The ICDS Plan must also demonstrate that the advisory committee composition reflects the diversity of the ICDS Beneficiary population, and participation of individuals with disabilities.

2.10. **Beneficiary Grievance and Appeals**

2.10.1. Grievance Filing

2.10.1.1. A Beneficiary may file an Internal Beneficiary Grievance at any time with the ICDS Plan by calling or writing to the ICDS Plan. A Beneficiary also may

file a Grievance at any time by calling or writing to CMS or ODM. If remedial action is requested, the Beneficiary must file the Grievance to the ICDS Plan or ODM no later than ninety (90) days after the event or incident triggering the Grievance.

2.10.1.1.1. In handling grievances and appeals, the ICDS Plan must give Beneficiaries all reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll free numbers with TTY/TDD and interpreter capability; and must inform Beneficiaries of the email address, postal address or toll-free telephone number where an Beneficiary Grievance may be filed.

2.10.2. Grievance Administration

2.10.2.1. Internal Grievance

2.10.2.1.1. The ICDS Plan must have a formally structured system in place for addressing Beneficiary Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA. The ICDS Plan must maintain written records of all Grievance activities, and notify CMS and ODM of all internal Grievances. The system must meet the standards specified in OAC rule 5160-58-08.4 and in 42 C.F.R. § 422.564.

2.10.2.1.2. A Beneficiary or authorized representative can file a Grievance. An authorized representative must have the Beneficiary's written consent to file a Grievance on the Beneficiary's behalf.

2.10.2.1.3. Grievances may be filed orally or in writing, only with the ICDS Plan, within ninety (90) calendar days of the date that the Beneficiary became aware of the issue.

2.10.2.1.4. The ICDS Plan must acknowledge the receipt of each Grievance to the individual filing the Grievance. Oral acknowledgment is acceptable; however, if the Grievance is filed in writing, written acknowledgment must be made within three (3) working days of receipt of the Grievance.

2.10.2.1.5. The ICDS Plan must ensure that decision makers on Grievances were not involved in previous levels of review or decision making, and are health care professionals with clinical expertise in treating the Beneficiary's condition for either of the following:

2.10.2.1.5.1. A grievance regarding denial of expedited resolutions of an appeal; or

2.10.2.1.5.2. Any grievance involving clinical issues.

2.10.2.1.6. The ICDS Plan must review and resolve all Grievances as expeditiously as the Beneficiary's health condition requires. Grievance resolutions including Beneficiary notification must meet the following timeframes:

2.10.2.1.6.1. Within twenty-four (24) hours if Grievance must be expedited pursuant to 42 C.F.R. § 422.564(f); or

2.10.2.1.6.2. Within thirty (30) calendar days of receipt for all other Grievances unless OAC rule 5160-58-08.4 requires less than thirty (30) calendar days.

2.10.2.1.7. At a minimum, the ICDS Plan must provide oral notification to the Beneficiary of a Grievance resolution. However, if the ICDS Plan is unable to speak directly with the Beneficiary and/or the resolution includes information that must be confirmed in writing, the resolution must be provided in writing simultaneously with the ICDS Plan's decision.

2.10.2.2. External Grievance

2.10.2.2.1. External Grievance Filing. The ICDS Plan must inform Beneficiaries of the email address, postal address or toll-free telephone number where a Beneficiary Grievance may be filed.

2.10.2.2.2. The ICDS Plan shall inform Beneficiaries that they may file an external Grievance through 1-800 Medicare.

2.10.2.2.3. The ICDS Plan must display a link to the electronic Complaint form on the Medicare.gov Internet Web site on the ICDS Plan's main Web page as required by 42 C.F.R. § 422.504(b)(15)(ii).

2.10.2.2.4. External Grievances filed with ODM shall be forwarded to the CMT and entered into the CMS complaints tracking module, which will be accessible to the ICDS Plan.

2.10.3. Beneficiary Appeals

2.10.3.1. General

2.10.3.1.1. Beneficiaries will continue to have full access to the Medicare and Medicaid Appeals frameworks for benefit Appeals. ICDS Plan must provide notice of Appeal rights in accordance with timeframes and content specified by CMS and ODM. The ICDS Plan must acknowledge the receipt of each Appeal to the individual filing the Appeal.

2.10.3.1.2. The ICDS Plan shall utilize and all Beneficiaries may access the existing Part D Appeals Process. Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare independent

review entity (IRE) if the ICDS Plan misses the applicable adjudication timeframe. The CMS IRE is contracted by CMS. The ICDS Plan must maintain written records of all Appeal activities, and notify CMS and ODM of all internal Appeals.

2.10.3.2. Integrated/Unified Non-Part D Appeals Process Overview:

2.10.3.2.1. Notice of Action – In accordance with 42 C.F.R. §§ 438.404 and 422.570, the ICDS Plan must give the Beneficiary written notice of any Adverse Action. For termination, suspension, or reduction of previously authorized Medicaid-covered services, such notice shall be provided at least (fifteen) 15 days in advance of the date of the action, in accordance with 42 C.F.R. § 438.404. Denials of any Medicare services will be required to comply with time frames at 42 C.F.R Part 422, Subpart M.

2.10.3.2.2. The ICDS Plan Appeal procedures must: (i) be submitted during readiness review and when requested, to the CMT in writing for prior approval by CMS and the ODM; (ii) provide for resolution with the timeframes specified herein; and (iii) assure the participation of individuals with authority to require corrective action. Appeals procedures must be consistent with 42 C.F.R. § 422.560 et seq. and 42 C.F.R. § 438.400 et seq. The ICDS Plan must have a committee in place for reviewing Appeals made by Beneficiaries. The ICDS Plan shall review its Appeal procedures at least annually for the purpose of amending such procedures when necessary. The ICDS Plan shall amend its procedures only upon receiving prior approval from the ODM.

2.10.3.3. Medicare A & B Service Appeals

2.10.3.3.1. Process: All initial Appeal requests will be filed with the ICDS Plan in accordance with applicable laws and regulations (Level One Appeal). If the ICDS Plan does not decide fully in the Beneficiary's favor within the relevant timeframe, the ICDS Plan shall automatically forward the case file regarding Medicare services to the Independent Review Entity (IRE) for a new and impartial review. If the Beneficiary disagrees with the IRE's decision, further levels of Appeal may be available, including a hearing before an Administrative Law Judge, and judicial review. The ICDS Plan must comply with any requests for information or participation from such further Appeal entities.

2.10.3.3.2. Timeframes: A Beneficiary may file an oral or written Appeal with the ICDS Plan within ninety (90) calendar days following the date of the notice of Adverse Action that generates such Appeal.

2.10.3.3.2.1. Unless a Beneficiary requests an expedited Appeal, for Level One Appeals filed with the ICDS Plan, the ICDS Plan shall render its decision on the Appeal within (fifteen) 15 calendar days after submission of the Appeal. The ICDS Plan may extend this timeframe for up to (fourteen) 14 calendar days if the Beneficiary requests an extension. If a Beneficiary requests an expedited Appeal, the ICDS Plan shall notify the Beneficiary, within twenty-four (24) hours after the submission of the Appeal, of all information from the Beneficiary that the ICDS Plan requires to evaluate the expedited Appeal. The ICDS Plan shall render a decision on an expedited Appeal within seventy-two (72) hours after receipt of the required information.

2.10.3.3.2.2. If the Level One Appeal is not fully in favor of the Beneficiary, the ICDS Plan must auto-forward the Appeal to the IRE. For standard Appeals, the IRE will send the Beneficiary and the ICDS Plan a letter with its decision within thirty (30) calendar days after it receives the case from the ICDS Plan, or at the end of up to a fourteen (14) calendar day extension, and a payment decision within sixty (60) calendar days. For expedited Appeals, the IRE will send the Beneficiary and the ICDS Plan a letter with its decision within seventy-two (72) hours after it receives the case from the ICDS Plan or at the end of up to a fourteen (14) calendar day extension.

2.10.3.3.2.3. If the IRE decides in the Beneficiary's favor and reverses the ICDS Plan's decision, the ICDS Plan must authorize the service under dispute as expeditiously as the Beneficiary's health condition requires, but no later than seventy-two (72) hours from the date the ICDS Plan receives the notice reversing the decision. Generally, the ICDS Plan must ensure that the services under dispute are provided as expeditiously as the Beneficiary's health condition requires, but no later than fourteen (14) calendar days from the date it receives notice that the IRE reversed the determination.

2.10.3.3.3. Continuation of Benefits Pending an Appeal: The ICDS Plan must provide continuing benefits for all previously approved non-Part D benefits that are being terminated or modified pending the ICDS Plan's internal Appeal process, subject to the requirements as indicated in 2.10.3.4.4. This means that such benefits, when requested by the beneficiary, will continue to be provided by Providers to Beneficiaries and that the ICDS Plans must continue to pay Providers for providing such previously authorized services or benefits pending an internal Appeal.

2.10.3.4. Medicaid Appeals

2.10.3.4.1. Process: An Appeal may be submitted orally or in writing. The ICDS Plan may not require the Beneficiary to follow an oral Appeal with a written, signed Appeal.

2.10.3.4.1.1. Initial appeals for Medicaid service denials, reductions, suspensions or terminations will be made to the ICDS Plan and/or the Ohio Department of Job and Family Services Bureau of State Hearings.

2.10.3.4.1.2. Appeal decisions for Medicaid services overruled by the ICDS Plan will not be auto-forwarded to the Bureau of State Hearings, but may be appealed by a Beneficiary to the Bureau.

2.10.3.4.2. The ICDS Plan must:

2.10.3.4.2.1. Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the Beneficiary or the provider requests expedited resolution;

2.10.3.4.2.2. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;

2.10.3.4.2.3. Allow the Beneficiary and the Beneficiary's representative the opportunity, before and during the appeals process, to examine the Beneficiary's case file, including medical records, and any other documents and records;

2.10.3.4.2.4. Consider the Beneficiary, his representative, or the estate representative of a deceased Beneficiary as parties to the appeal;

2.10.3.4.2.5. Ensure that decision makers on Appeals were not involved in previous levels of review or decision making, and are health care professionals with clinical expertise in treating the Beneficiary's condition for either of the following:

2.10.3.4.2.5.1. A denial Appeal based on lack of medical necessity; or

2.10.3.4.2.5.2. Any Appeal involving clinical issues.

2.10.3.4.3. Time frames- Time frames for filing Appeal related to benefits:

2.10.3.4.3.1. Beneficiaries or their authorized representatives will have ninety calendar (90) days from the date that the Notice of Action is mailed to file an Appeal related to a denial, or reduction, suspension or termination of authorized Medicaid benefits covered by the ICDS Plan.

2.10.3.4.3.2. The ICDS Plan shall render its decision on the Appeal within fifteen (15) calendar Days after submission of the Appeal. The ICDS Plan may extend this timeframe for up to fourteen (14) calendar days if the Beneficiary requests an extension, or if the ICDS Plan demonstrates to the satisfaction of the ODM that there is a need for additional information, the ICDS plan demonstrates that the delay is in the Beneficiary's interest, and the Plan provides the Beneficiary with written notice of the reason for the delay. The ICDS Plan shall provide the Beneficiary with written notice of the resolution pursuant to 42 C.F.R. § 438.408.

2.10.3.4.3.3. If a Beneficiary requests an expedited Appeal pursuant to 42 C.F.R. § 438.410, the ICDS Plan shall inform the Beneficiary of the limited time available for the Beneficiary to present evidence, and allegations of fact or law, in person as well as in writing and make a determination in accordance with OAC Rule 5160-58-08.4. The ICDS Plan shall render a decision on an expedited Appeal within seventy-two (72) hours after receipt of the required information; the ICDS plan shall provide written notice and shall make reasonable efforts to provide oral notice. If the ICDS Plan denies the expedited Appeal, the ICDS Plan shall ensure that it complies with the procedures in 42 C.F.R. § 438.410(c). The ICDS Plan may extend this timeframe for up to fourteen (14) calendar days if the Beneficiary requests an extension, or if the ICDS Plan demonstrates to the satisfaction of ODM that there is a need for additional information and the delay is in the Beneficiary's interest, and the ICDS Plan provides the Beneficiary with written notice of the reason for the delay. The ICDS Plan must ensure that no punitive action is taken against a Provider that either requests an expedited Appeal or that supports a Beneficiary's expedited Appeal.

2.10.3.4.3.4. A Beneficiary may request an external appeal hearing before the Bureau of State Hearings within 90 days of the ICDS Plan's notice of action. Parties to the external Appeal include the Beneficiary, his/her representative, or the representative of the Beneficiary's estate, and the ICDS Plan. The Bureau of State Hearings, within the Ohio Department of Job and Family Services, will resolve Medicaid state hearings as expeditiously as the Beneficiary's condition requires, but always within ninety calendar (90) days of request for the first year of the Demonstration, sixty calendar (60) days of request for the 2nd year of the Demonstration, and within thirty (30) calendar days of request in the 3rd year.

2.10.3.4.3.5.

The Bureau of State Hearings will resolve within three (3) working days from the date of Bureau's receipt of the request the following: hearing requests related to a denial of services that meet the criteria for an expedited appeals process but which the ICDS plan did not resolve using expedited appeals timeframes, or were resolved wholly or partially adversely to the Beneficiary using the ICDS plan's expedited appeals timeframes; or hearing requests made directly to the Bureau of State Fair Hearings for denials of services that meet the criteria for an expedited appeals process.

2.10.3.4.3.6. Timeframe of less than ninety (90) days will not apply when any of the following occurs: 1.) the Bureau requests a policy/legal clarification; 2.) an act of nature or unexpected disaster causes a delay; 3.) the Bureau's receipt of the request is more than ten calendar (10) days after the initial request; 4.) the Beneficiary requests a delay, postponement or reschedule of the hearing; 5.) the hearing is reconvened; or 6.) the hearing record is left open pending additional information.

2.10.3.4.3.7. ICDS Plan will toll applicable time frames for Medicare service Appeals that have been inappropriately made to the Bureau of State Hearings within the State instead of the ICDS Plan. The Bureau of State Hearings will forward misdirected appeals to the ICDS Plan for a determination.

2.10.3.4.4. Continuation of Medicaid Benefits Pending an Appeal

2.10.3.4.4.1. As provided in OAC rule 5160-58-08.4, if a Beneficiary files an Appeal within fifteen (15) calendar days after the date of a notice of Adverse Action from the ICDS Plan or the effective date of the proposed action and the Beneficiary requests that the disputed Covered Services be continued pending the Appeal, continuation of all previously authorized non-part D benefits will be required to be provided pending internal appeals. As provided in 42 C.F.R. §§ 431.211 and 230, continuations of covered Medicaid services will continue to be required when a hearing request is made to the Bureau of State Hearings within fifteen (15) calendar days of the date the notice is mailed or the effective date of the proposed action, whichever is later. This means that benefits previously authorized by the ICDS Plan and for which the authorization period has not expired and for which the Beneficiary requests continuation, will continue to be provided by Providers to Beneficiaries, and that the ICDS Plan

must continue to pay Providers for providing services pending an internal ICDS Plan Appeal or state hearing request. Payments will not be recouped based on the outcome of the Appeal for services covered during pending Appeals.

2.10.3.5. Medicare A & B/Medicaid Appeals (Overlap Services and Items)

2.10.3.5.1. Process: For services and items in which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies), all initial Appeal requests will be filed with the ICDS Plan in accordance with applicable laws and regulations.

2.10.3.5.2. Timelines: A Beneficiary may file an oral or written Appeal with the ICDS Plan within ninety (90) calendar days following the mailing date of the notice of Adverse Action that generates such Appeal for his or her overlapping benefits.

2.10.3.5.2.1. For Appeals filed with the ICDS Plan, if the Beneficiary does not request an expedited Appeal, the ICDS Plan shall render its decision on the Appeal within fifteen (15) Calendar Days after submission of the Appeal. The ICDS Plan may extend this timeframe for up to fourteen (14) calendar days if the Beneficiary requests an extension, or if the ICDS Plan demonstrates to the satisfaction of ODM that there is a need for additional information and the delay is in the Beneficiary's interest.

2.10.3.5.2.2. If a Beneficiary requests an expedited Appeal, the ICDS Plan shall notify the Beneficiary, within twenty-four (24) hours after the submission of the Appeal, of all information from the Beneficiary that the ICDS Plan requires to evaluate the expedited Appeal. The ICDS Plan shall render a decision on an expedited Appeal within seventy-two (72) hours after receipt of the required information. If the Beneficiary does not request an expedited Appeal, the ICDS Plan shall render a decision within fifteen (15) business days after receipt of the Appeal and shall provide the Beneficiary with written notice of the resolution.

2.10.3.5.2.3. If the Appeal is not fully in favor of the Beneficiary, the ICDS Plan must auto-forward the Appeal to the IRE. For standard Appeals, the IRE will send the Beneficiary and the ICDS Plan a letter with its decision within thirty (30) calendar days after it receives the Appeal file from the ICDS Plan, or at the end of up to a fourteen (14) calendar day extension, and a payment decision within sixty (60) calendar days. For expedited Appeals, the IRE will send the

Beneficiary and the ICDS Plan a letter with its decision within seventy-two (72) hours after it receives the Appeal file from the ICDS Plan or at the end of up to a fourteen (14) calendar day extension.

2.10.3.5.2.4. If the IRE decides in the Beneficiary's favor, whether in whole or in part, the ICDS Plan must authorize the service under dispute as expeditiously as the Beneficiary's health condition requires, but no later than seventy-two (72) hours from the date the ICDS Plan receives the notice of the decision.

2.10.3.5.2.5. If an Appeal is filed with the Bureau of State Hearings, ODM will issue Final Administrative Decisions for Standard Appeals within ninety (90) calendar days of hearing request for the first year of the Demonstration, sixty calendar (60) days of the hearing request for the 2nd year of the Demonstration, and within thirty (30) calendar days of the hearing request in the 3rd year. Final Administrative Decisions for Expedited Appeals will be issued within three (3) business days after the filing of an Appeal with the State Fair Hearing Agency. The ICDS Plan will participate in the pre-hearing process, including, but not limited to, scheduling coordination and submission of documentary evidence at least three (3) business days prior to the hearing, and shall participate in the hearing, including providing a witness to offer testimony supporting the decision of the ICDS Plan.

2.10.3.5.2.6. Continuation of Benefits Pending an Appeal: Pursuant to procedures and requirements documented in OAC rule 5160-58-08.4, the ICDS Plan must provide continuing benefits, when requested by the beneficiary, for all previously authorized non-Part D benefits that are being terminated or modified pending the ICDS Plan's internal Appeal process. If the ICDS Plan does not decide fully in the Beneficiary's favor within the relevant timeframe, the ICDS Plan must continue providing benefits for any previously authorized non-Part D benefits that are being terminated or modified through the period of IRE review or State Hearing decision period. This means that benefits previously authorized by the ICDS Plan and for which the authorization period has not expired and for which the Beneficiary requests continuation, will continue to be provided by Providers to Beneficiaries, and that the ICDS Plan must continue to pay Providers for providing services pending an internal ICDS Plan Appeal or state hearing request or IRE review. Payments will not be recouped based

on the outcome of the Appeal for services covered during pending Appeals.

2.10.3.6. Integrated Notice. Beneficiaries will be notified of all applicable Demonstration, Medicare and Medicaid Appeal rights through a single notice. The form and content of the notice must be based on elements of OMB approved CMS-1003 and prior approved by CMS and ODM. The ICDS Plan shall notify the Beneficiary of its decision at least fifteen (15) calendar days in advance of the date of its action, and simultaneous with the decision, when applicable.

2.10.3.6.1. The notice must explain:

2.10.3.6.1.1. The action the ICDS Plan has taken or intends to take;

2.10.3.6.1.2. The reasons for the action;

2.10.3.6.1.3. The citation to the regulations supporting such action;

2.10.3.6.1.4. The Beneficiary's or the authorized representative's right to file an Appeal;

2.10.3.6.1.5. Procedures for exercising Beneficiary's rights to Appeal;

2.10.3.6.1.6. Circumstances under which expedited resolution is available and how to request it;

2.10.3.6.1.7. If applicable, the Beneficiary's rights to have benefits continue pending the resolution of the Appeal;

2.10.3.6.1.8. The date the notice is being issued;

2.10.3.6.1.9. Oral interpretation is available for any language;

2.10.3.6.1.10. Written alternative formats may be available as needed; and

2.10.3.6.1.11. How to access the ICDS Plan's interpretation and translation services as well as alternative formats that can be provided by the ICDS Plan.

2.10.3.6.2. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs.

2.10.4. Hospital Discharge Appeals

2.10.4.1. When a Beneficiary is being discharged from the hospital, the ICDS Plan must assure that the Beneficiary receives a written notice of explanation called an *Important Message from Medicare About your Rights* regarding the right to appeal the discharge decision from an inpatient hospital admission.

2.10.4.2. The Beneficiary has the right to request a review by a Quality Improvement Organization (QIO) of any hospital discharge notice. The notice includes information on filing the QIO Appeal. The Beneficiary must contact the QIO before he/she leaves the hospital but no later than the planned discharge date.

2.10.4.3. If the Beneficiary asks for immediate review by the QIO, the Beneficiary is entitled to this process instead of the standard Appeals process described above. The ICDS Plan must ensure that the Beneficiary receives the *Detailed Notice of Discharge (CMS-10066)*. Note: a Beneficiary may file an oral or written request for an expedited seventy-two (72) hour ICDS Plan Appeal if the Beneficiary has missed the deadline for requesting the QIO review.

2.10.4.4. The QIO will make its decision within one calendar day after it receives the Beneficiary's request, medical records, and any other information it needs to make its decision.

2.10.4.5. If the QIO agrees with the ICD Plan's decision, the ICDS Plan is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Beneficiary of its decision.

2.10.4.6. If the QIO overturns the ICDS Plan's decision, the ICDS Plan must pay for the remainder of the hospital stay.

2.10.5. Additional Medicare QIO rights, including those that relate to individuals in a Comprehensive Outpatient Rehabilitation Facility (CORF), Skilled Nursing Facilities (SNF), or receiving Medicare Home Health benefits, will continue to be available pursuant to existing Medicare law, regulations and guidance.

2.11. **Quality Assessment and Performance Improvement Program**

2.11.1. Quality Improvement (QI) Program

2.11.1.1. The ICDS Plan shall:

2.11.1.2. Deliver quality care that enables Beneficiaries to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.11.1.2.1. Quality of physical health care, including primary and specialty care;

2.11.1.2.2. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;

2.11.1.2.3. Quality of LTSS;

2.11.1.2.4. Adequate access and availability to primary, behavioral health care, specialty health care, and LTSS providers and services;

2.11.1.2.5. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.11.1.2.6. Beneficiary experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

2.11.1.3. Have in effect mechanisms to assess the quality and appropriateness of care furnished to Beneficiaries with special health care needs.

2.11.1.4. Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the ICDS Plan's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.11.1.4.1. Quantitative and qualitative data collection and data-driven decision-making;

2.11.1.4.2. Adoption and dissemination, as appropriate, to network Providers (and to Beneficiaries and potential Beneficiaries upon request) of up-to-date evidence-based practice guidelines that meet the requirements of 42 C.F.R. § 438.236 and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.11.1.4.3. Feedback that may be solicited from external stakeholders (e.g., Beneficiaries and Providers) in the design, planning, and implementation of its CQI activities; and

2.11.1.4.4. Issues identified by the ICDS Plan, ODM and/or CMS.

2.11.1.5. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health services and LTSS.

2.11.2. QI Program Structure

2.11.2.1. The ICDS Plan shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the ICDS Plan's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The ICDS Plan's QI organizational and program structure shall comply with all applicable provisions of 42 CFR § 438, Subpart D, Quality Assessment and Performance Improvement, 42 CFR § 422, Subpart D

Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements. Specifically, the ICDS Plan shall establish procedures such that the ICDS Plan shall be able to demonstrate that it meets the requirements of the HMO Federal qualification regulations (42 C.F.R. § 417.106), the Medicare HMO/CMP regulations (42 C.F.R. § 417.418(c)), and the regulations promulgated pursuant to the Balanced Budget Act of 1997 (42 C.F.R. § 438.200 et seq.).

2.11.2.2. These regulations require that the ICDS Plan have an ongoing fully implemented Quality Program for health services and shall :

2.11.2.2.1. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.11.2.2.2. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the ICDS Plan's service delivery system;

2.11.2.2.3. Establish internal processes to ensure that the quality program activities for primary, specialty, and behavioral health services, and LTSS reflect utilization across the Provider Network and include all of the activities in this Section of this Contract and, in addition, the following elements:

2.11.2.2.3.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Care Management Program Evaluation Data, Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.11.2.2.3.2. A medical record review process, consistent with 42 C.F.R. Part 456, for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care;

2.11.2.2.3.3. A process to measure network Providers and Beneficiaries, at least annually, regarding their satisfaction with the ICDS Plan. The ICDS Plan shall submit a survey plan to ODM for approval and shall submit the results of the survey to ODM and CMS;

2.11.2.2.3.4. A process to measure clinical reviewer consistency in applying clinical criteria to Utilization Management activities, using inter-rater reliability measures; and

2.11.2.2.3.5. A process for including Beneficiaries and their families in QI activities, as evidenced by participation in consumer advisory boards.

2.11.2.2.4. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the ICDS Plan's QI initiatives. Such description shall:

2.11.2.2.4.1. Address all aspects of health care, including specific references to behavioral health care and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description;

2.11.2.2.4.2. Establish a quality measurement assessment and improvement strategy as specified by ODM.

2.11.2.2.4.3. Address the roles of the designated physician(s), behavioral health clinician(s), and LTSS providers with respect to QI program;

2.11.2.2.4.4. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.11.2.2.4.5. Include organization-wide policies and procedures that document processes through which the ICDS Plan ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and Utilization Management;

2.11.2.2.4.6. Ensure that decisions for utilization management, Beneficiary education, coverage of services, and other areas to which practice guidelines apply shall be made consistent with the guidelines.

2.11.2.2.5. Submit to ODM and CMS an annual QI Work Plan that shall include the following components or other components as directed by ODM and CMS:

2.11.2.2.5.1. Planned clinical and non-clinical initiatives;

2.11.2.2.5.2. The objectives for planned clinical and non-clinical initiatives;

2.11.2.2.5.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.11.2.2.5.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.11.2.2.5.5. Any issues identified by the ICDS Plan, ODM, Beneficiaries, and Providers, and how those issues are tracked and resolved over time;

2.11.2.2.5.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.11.2.2.6. Process for correcting deficiencies.

2.11.2.3. The ICDS Plan shall evaluate the results of QI initiatives at least quarterly, and submit the results of the evaluation upon request to the ODM, QI Director and CMT. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the ICDS Plan's assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan.

2.11.2.4. The ICDS Plan shall maintain sufficient and qualified staff employed by the ICDS Plan to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QI. QI staff shall include:

2.11.2.4.1. At least one (1) designated physician, who shall be a medical director or associate medical director, at least one (1) designated behavioral health clinician, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program; and

2.11.2.4.2. QI Director as outlined in Section 2.2.3.4.1.6.

2.11.2.5. The ICDS Plan shall actively participate in, or assign staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by ODM, or an ICDS Plan, that may be attended by representatives of ODM, or an ICDS Plan, and other entities, as appropriate; and

2.11.2.6. Serve as liaison to, and maintain regular communication with, ODM QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

2.11.3. QI Activities

2.11.3.1. The ICDS Plan shall engage in performance measurement and QI projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Beneficiary experience.

2.11.3.2. The ICDS Plan's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 438.242, 422.516(a) and 423.514.

2.11.3.3. Performance Measurement

2.11.3.3.1. The ICDS Plan shall perform and report the quality and utilization measures identified by CMS and ODM and in accordance with requirements in the Memorandum of Understanding between CMS and State of Ohio (December 12, 2012), Figure 7-1 Core Quality Measures, and as articulated in this Contract, and shall include, but are not limited to:

2.11.3.3.1.1. All HEDIS, Health Outcomes Survey (HOS) and CAHPS data, as well as all other measures specified in Figure 7-1 Core Quality Measures of the MOU referenced above (Figure 7-1). HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.11.3.3.2. The ICDS Plan shall collect annual data and contribute to all Demonstration QI-related processes, as directed by ODM and CMS, as follows:

2.11.3.3.2.1. Collect and submit to ODM, CMS and/or CMS' contractors, in a timely manner, data for the measures specified in Figure 7-1; and

2.11.3.3.2.2. Contribute to all applicable ODM and CMS data quality assurance processes.

2.11.3.3.3. Beneficiary Experience Surveys

2.11.3.3.3.1. The ICDS plan must contract with an approved survey vendor to collect and report Medicare CAHPS survey data on

an annual basis following a timeline and protocols established by CMS and/or ODM.

2.11.3.3.4. Ohio-Specific Performance Measures Used for Compliance Monitoring

2.11.3.3.4.1. The ICDS plan is evaluated on each ODM required measure using statewide results that include all regions in which the ICDS Plan has membership. Results for each measure are calculated per ICDS plan and include all of the ICDS Plan's Beneficiaries who meet the criteria specified by the methodology for the given measure. A comprehensive description of the measures and methodology used to calculate the results for each measure will be provided in additional guidance for the upcoming reporting year.

2.11.3.3.4.2. Noncompliance with Ohio-Specific Performance Standards

2.11.3.3.4.2.1. An ICDS Plan will be assessed penalties as specified in the Compliance Methodology for the upcoming reporting year for instances of noncompliance with Ohio-specific performance standards, also published in separate guidance.

2.11.3.4. Performance/Quality Improvement Project Requirements

2.11.3.4.1. The ICDS Plan shall implement and adhere to all processes relating to the performance improvement project and quality improvement (QI) project requirements, as directed by ODM and CMS, as follows:

2.11.3.4.1.1. In accordance with 42 C.F.R. § 438.240 (d) and 42 C.F.R. § 422.152 (d), collect information and data in accordance with performance improvement and QI project requirement specifications for its Beneficiaries, using the format and submission guidelines specified by ODM and CMS in annual guidance provided for the upcoming contract year;

2.11.3.4.1.2. Implement performance improvement project topics as specified by ODM and CMS. Potential topics include long term services and supports, nursing facility care and/or rebalancing and diversion from nursing facilities;

2.11.3.4.1.3. Implement the QI project requirements, in a culturally competent manner, to achieve objectives as specified by CMS and ODM;

2.11.3.4.1.3.1. QI projects must achieve, through periodic measurements and intervention, significant and sustained

improvement in clinical and non-clinical areas which are expected to have a favorable impact on health outcomes and satisfaction. The ICDS Plan must adhere to CMS and ODM specifications for QI project content, format and submission.

2.11.3.4.1.3.2. All QI project submissions must be reviewed and approved by ODM and CMS. In addition, the ICDS Plan must submit on an annual basis to ODM the status and results of each QI project. The EQRO will assist ICDS Plans with the development and implementation of QI projects by providing technical assistance and will complete an annual validation of the QI projects.

2.11.3.4.1.4. Evaluate the effectiveness of QI interventions;

2.11.3.4.1.5. Plan and initiate processes to sustain achievements and continue improvements;

2.11.3.4.1.6. Submit documentation to ODM and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by ODM and CMS.

2.11.3.4.1.7. In accordance with 42 C.F.R. § 422.152 (c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the ICDS's plan population. Although the ICDS Plan has the flexibility to choose the design of their CCIPs, ODM and CMS may require them to address specific topic areas.

2.11.3.4.2. CMS-Specified Performance Measurement and Performance Improvement Projects

2.11.3.4.2.1. The ICDS Plan shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.240(a)(2).

2.11.4. External Quality Review (EQR) Activities

2.11.4.1. The ICDS Plan must participate in annual external quality review activities as specified in OAC 5160-58-01.1 and 5160-26-07. The ICDS Plan shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by the ODM and the Quality Improvement Organization (QIO) to conduct External Quality Review (EQR) Activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. The review will include but not be limited to the following activities:

2.11.4.1.1. Administrative compliance assessments as specified at 42 .C.FR. § 438.358 and as specified by ODM. ODM may allow non-duplication exemption in accordance with 42 C.F.R. § 438.360 and 42 C.F.R. § 438.362;

2.11.4.1.2. Focused reviews of ICDS Plan compliance with program requirements (e.g., care management, coordination and continuity of care) as specified by ODM;

2.11.4.1.3. Encounter data studies;

2.11.4.1.4. Validation of performance measurement data;

2.11.4.1.5. Review of information systems;

2.11.4.1.6. Validation of performance improvement projects; and

2.11.4.1.7. Consumer satisfaction, experience of care, care management or quality of life surveys.

2.11.4.2. Penalties for noncompliance with external quality review activities are listed in a Compliance Assessment Policy document maintained by ODM and available on ODM's website.

2.11.5. Clinical Practice Guidelines: All services provided by or arranged to be provided by the ICDS Plan shall be in accordance with prevailing professional community standards. All clinical practice guidelines shall be based on established evidence-based best practice standards of care, promulgated by leading academic and national clinical organizations, or as otherwise required by ODM or CMS, and shall be adopted by the ICDS Plans with sources referenced and guidelines documented in ICDS Plan's QI Program. Such guidelines should consider the needs of Beneficiaries, including assessing the quality and appropriateness of care furnished to Beneficiaries with special needs; and are reviewed and updated periodically as appropriate.

2.11.6. Addressing Health Disparities: The ICDS Plan must participate in, and support, ODM's efforts to eliminate health disparities in Ohio. The ICDS Plan will be required to participate in a Health Equity Workgroup (HEW) which will, at a minimum, be comprised of representatives from each ICDS Plan, ODM, Ohio Commission on Minority Health, and the ODH. The HEW will be charged with characterizing the extent of health care disparities among Beneficiaries by establishing common health disparity measures and developing a strategy to address disparities revealed by the results of the measures. When establishing disparity measures, the HEW will determine the data elements (e.g., self-identified race, ethnicity, and language) needed to calculate the health

disparity measures. The ICDS Plan will collect the data elements and calculate the results of the measures to inform the development of the strategy.

2.12. **Marketing, Outreach, and Beneficiary Communications Standards**

2.12.1. General Marketing, Outreach, and Beneficiary Communications Requirements

2.12.1.1. The ICDS Plan is subject to rules governing marketing and Beneficiary Communications as specified under Section 1851(h) of the Social Security Act; 42 CFR § 422.111, § 422.2260 et. seq., § 423.120(b) and (c), § 423.128, 423.2260 et. seq and § 438.104 §; the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual), and the Ohio Medicare-Medicaid Plan Marketing Guidance with the following exceptions or modifications:

2.12.1.1.1. The ICDS Plan must refer Beneficiaries and Potential Beneficiaries who inquire about MyCare Ohio eligibility or enrollment to the enrollment broker, although the ICDS Plan may provide Beneficiaries and Potential Beneficiaries with factual information about the ICDS Plan and its benefits prior to referring a request regarding eligibility or Enrollment to the State Enrollment Vendor;

2.12.1.1.2. The ICDS Plan must make available to CMS and ODM, upon request, current schedules of all educational events conducted by or in which the ICDS Plan participates, with intent to provide information to Beneficiaries or Potential Beneficiaries;

2.12.1.1.3. The ICDS Plan-initiated educational events must be convened at sites within the ICDS Plan's Service Area that are physically accessible to all Beneficiaries or Potential Beneficiaries, including persons with disabilities and persons using public transportation; and distributes the materials to its entire service area as indicated in Appendix H of this Contract.

2.12.1.1.4. The ICDS Plan may <u>not</u> offer financial or other incentives, including private insurance, to induce Beneficiaries or Potential Beneficiaries to enroll with the ICDS Plan or to refer a friend, neighbor, or other person to enroll with the ICDS Plan.

2.12.1.1.5. Prior to initiating Beneficiary-requested marketing contact with a current or pending ICDS Beneficiary for any corporate-family MA or SNP product, an ICDS Beneficiary services or Care Management contact must identify and resolve any confusion or service issues that may have motivated the Beneficiary's request for a change in Enrollment. The

ICDS BSR or Care Manager must also educate the Beneficiary about the ICDS Plan benefits and mandatory ICDS enrollment for Medicaid services. Once the issues are resolved and clarification about integrated Enrollment is made, the Beneficiary must be invited to rescind the marketing request. ODM and CMS will measure Enrollment of eligible Beneficiaries in contracted MA plans and apply financial sanctions in accordance with the terms of Section 5.3 of the Contract.

2.12.1.1.6. The ICDS Plan may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts; and

2.12.1.1.7. The ICDS Plan may not use any Marketing, Outreach, or Beneficiary Communications materials that contain any assertion or agreement (whether written or oral) that:

2.12.1.1.7.1. The Beneficiary must enroll with the ICDS Plan in order to obtain benefits or in order not to lose benefits; and

2.12.1.1.7.2. The ICDS Plan is endorsed by CMS, Medicare, Medicaid, the federal government, ODM, or similar entity.

2.12.2. The ICDS Plan's Marketing, Outreach, and Beneficiary Communications materials must be:

2.12.2.1. Made available in alternative formats, upon request and as needed to assure effective communication for blind and vision-impaired Beneficiaries;

2.12.2.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with cognitive impairments;

2.12.2.3. Translated into Prevalent Languages for all vital materials, as specified in the Medicare Medicaid Marketing Guidelines and annual guidance to ICDS Plans on specific translation requirements for their service areas; and

2.12.2.4. Mailed with a multi-language insert that indicates that the Beneficiary can access free interpreter services to answer any questions about the plan. This message shall be written in the languages required in the Medicare Marketing Guidelines provisions on the multi-language insert and any additional languages indicated in the Medicare-Medicaid marketing guidance.

2.12.3. Submission, Review, and Approval of Marketing, Outreach, and Beneficiary Communications Materials

2.12.3.1. The ICDS Plan must receive prior approval of all marketing and Beneficiary communications materials in categories of materials that CMS and ODM require to be prospectively reviewed. ICDS Plan materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §

422.2262(b) and § 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and ODM. CMS and ODM may agree to defer to one or the other party for review of certain types of marketing and Beneficiary communications, as agreed in advance by both parties. The ICDS Plan must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

2.12.3.2. CMS and ODM may conduct additional types of review of ICDS Plan marketing, outreach, and Beneficiary Communications activities, including, but not limited to:

2.12.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits;

2.12.3.2.2. Random review of actual marketing, outreach, and Beneficiary communications pieces as they are used in the marketplace;

2.12.3.2.3. "For cause" review of materials and activities when complaints are made by any source, and CMS or ODM determine it is appropriate to investigate; and

2.12.3.2.4. "Secret shopper" activities where CMS or ODM request ICDS Plan materials, such as enrollment packets.

2.12.3.3. Beginning of Marketing, Outreach and Beneficiary Communications Activity

2.12.3.3.1. The ICDS Plan may not begin Marketing, Outreach, and Beneficiary Communications activities to new Beneficiaries more than ninety (90) days prior to the effective date of the Contract.

2.12.4. Requirements for Dissemination of Marketing, Outreach, and Beneficiary Communications Materials

2.12.4.1. Consistent with the timelines specified in the Medicare-Medicaid marketing guidance, the Contractor must provide Beneficiaries with the following materials which, with the exception of materials specified in Sections 2.12.4.2 and 2.12.4.3, must be provided annually thereafter:

2.12.4.1.1. An Evidence of Coverage (EOC)/Member Handbook document that is consistent with the requirements at 42 C.F.R. §§ 438.10, 422.411, and 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMS and ODM.

2.12.4.1.2. Beneficiary rights (see Appendix B);

2.12.4.1.3. An explanation of the centralized enrollee record and the process by which clinical information, including diagnostic and medication information, will be available to authorized caregivers;

2.12.4.1.4. How to obtain a copy of the Beneficiary's centralized enrollee record;

2.12.4.1.5. How to obtain access to specialty, behavioral health, pharmacy and LTSS Providers;

2.12.4.1.6. How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.12.4.1.6.1. What constitutes Emergency Medical Condition, Emergency Services, and Post-stabilization Services;

2.12.4.1.6.2. The fact that Prior Authorization is not required for Emergency Services;

2.12.4.1.6.3. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.12.4.1.6.4. The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Contract;

2.12.4.1.6.5. That the Beneficiary has a right to use any hospital or other setting for emergency care; and

2.12.4.1.6.6. The Post-stabilization Care Services rules at 42 C.F.R. § 422.113(c).

2.12.4.1.7. Information about advance directives (at a minimum those required in 42 C.F.R. §§ 489.102 and 422.128), including Beneficiary rights under the law of Ohio; the ICDS Plan's policies respecting the implementation of those rights, including any limitation regarding the implementation of advance directives as a matter of conscience; that complaints concerning noncompliance with the advance directive requirements may be filed with ODM; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Beneficiary;

2.12.4.1.8. How to obtain assistance from BSRs;

2.12.4.1.9. How to file Grievances and internal and external Appeals, including:

2.12.4.1.9.1. Grievance, Appeal and fair hearing procedures and timeframes;

2.12.4.1.9.2. Toll free numbers that the Beneficiary can use to file a Grievance or an Appeal by phone; and

2.12.4.1.9.3. That when requested by the Beneficiary and in accordance with the requirements specified by CMS and OAC rule 5160-58-08.4, benefits will continue at the plan level for all benefits, and if the Beneficiary files an Appeal or a request for Ohio fair hearing within the timeframes specified for filing.

2.12.4.1.10. How the Beneficiary can authorize another person to receive written notices of denials, terminations, and reductions;

2.12.4.1.11. How to obtain assistance with the Appeals processes through the BSR and other assistance mechanisms as ODM or CMS may identify, including an Ombudsperson;

2.12.4.1.12. The extent to which, and how Beneficiaries may obtain benefits, including family planning services, from out-of-network Providers;

2.12.4.1.13. How to change Providers; and

2.12.4.1.14. Waiver Beneficiary Handbook model language provided by the State for individuals enrolled in the HCBS waiver.

2.12.4.1.15. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the ICDS Plan, as well as the benefits offered under the ICDS Plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and the ODM. The SB should provide sufficient detail to ensure that Beneficiaries understand the benefits to which they are entitled. For new Beneficiaries, the SB is required only for individuals enrolled through Passive Enrollment. For current Beneficiaries, the SB must be sent with the Annual Notice of Change (ANOC) as described in the Medicare-Medicaid marketing guidance.

2.12.4.1.16. A combined provider and pharmacy directory that is consistent with the requirements in Section 2.12.5.

2.12.4.1.17. A single identification (ID) card for accessing all covered services under the plan that uses the model document developed by CMS and ODM.

2.12.4.1.18. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and the ODM's outpatient prescription drug benefit and that uses the model document developed by CMS and ODM.

2.12.4.1.19. The procedures for a Beneficiary to change ICDS Plans or to Opt Out of the Demonstration.

2.12.4.2. The ICDS Plan must provide the following materials to current Beneficiaries on an ongoing basis:

2.12.4.2.1. An Annual Notice of Change (ANOC) that summarizes all major changes to the ICDS Plan's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and ODM.

2.12.4.2.2. A combined pharmacy/provider directory as frequently as specified in Section 2.12 and as needed to replace old versions or upon an Beneficiary's request; and

2.12.4.2.3. As needed to replace old versions or upon a Beneficiary's request, a single ID card for accessing all Covered Services under the plan.

2.12.4.3. The ICDS Plan must provide all Medicare Part D required notices, with the exception of the late enrollment penalty and creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual. Consistent with the requirement at 42 CFR §423.120(b)(5), the ICDS Plan must provide Beneficiaries with at least sixty (60) days advance notice regarding changes to the comprehensive, integrated formulary.

2.12.4.4. The ICDS Plan must ensure that all information provided to Beneficiaries and Potential Beneficiaries (and families or caregivers when appropriate) is provided in a manner and format that is easily understood and that is:

2.12.4.4.1. Made available in large print (at least 16 point font) to Beneficiaries as an alternative format, upon request;

2.12.4.4.2. Available in Prevalent Languages as directed by ODM and CMS;

2.12.4.4.3. Written with cultural sensitivity and at a sixth grade reading level; and

2.12.4.4.4. Available in alternative formats, according to the needs of Beneficiaries and Potential Beneficiaries, including Braille, oral interpretation services in non-English languages, as specified in Section 2.9 of this Contract; audiotape; ASL video clips, and other alternative media, as requested.

2.12.4.4.5. The ICDS Plan will provide information available upon the Beneficiary's request:

2.12.4.4.5.1. Information on the structure and operation of the ICDS Plan; and

2.12.4.4.5.2. Physician incentive plans as set forth in 42 C.F.R. § 438.6(h).

2.12.5. Provider/Pharmacy Network Directory

2.12.5.1. Maintenance and Distribution: The ICDS Plan must:

2.12.5.1.1. Maintain a combined Provider/Pharmacy Network directory that uses the model document developed by CMS and ODM;

2.12.5.1.2. Provide either a copy or information about how to access a copy, as specified in the Medicare-Medicaid marketing guidance, to all new Beneficiaries at the time of Enrollment and, upon request, to both new and continuing Beneficiaries.

2.12.5.1.3. Provide a copy or information about how to access a copy, as specified in the Medicare-Medicaid marketing guidance, at least every three (3) years after the time of Enrollment, unless there is a significant change to the Provider Network, in which case the ICDS Plan must send a special mailing of an updated directory or information about the network change and how to access a copy, as specified in the Medicare-Medicaid marketing guidance, immediately;

2.12.5.1.4. Ensure an up-to-date copy is available on the ICDS Plan's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 42 C.F.R. 423.128(d);

2.12.5.1.5. On a quarterly basis, the ICDS Plan must create an insert to each printed Provider Directory that lists those Providers deleted from the ICDS's provider panel during the previous three (3) months. Although this insert does not need to be prior approved by ODM, a copy of the insert must be submitted to ODM prior to distribution to Beneficiaries;

2.12.5.1.6. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy at least thirty calendar days before the termination effective date to all Beneficiaries who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all Beneficiaries who are patients of that primary care professional must be notified; and

2.12.5.1.7. Include written and oral offers of such Provider/Pharmacy Network directory in its outreach and orientation sessions for new Beneficiaries.

2.12.5.2. Content of Provider/Pharmacy Network Directory

2.12.5.2.1. The Provider/Pharmacy Network directory must include, at a minimum, the following information for all providers/pharmacies in the ICDS Plan's Provider/Pharmacy Network:

2.12.5.2.1.1. The names, addresses, and telephone numbers of all current network Providers and pharmacies.

2.12.5.2.1.2. Network Providers with areas of special experience, skills and training, including Providers with expertise in treating:

2.12.5.2.1.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS,

2.12.5.2.1.2.2. Persons with serious mental illness;

2.12.5.2.1.2.3. Homeless persons;

2.12.5.2.1.2.4. Persons who are Deaf or hard-of-hearing and blind or visually impaired;

2.12.5.2.1.2.5. Persons with co-occurring disorders; and

2.12.5.2.1.2.6. Other specialties.

2.12.5.2.2. Office hours for each network Provider, including the names of any network Provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;

2.12.5.2.3. An explanation of how to access Providers (e.g. referral required vs. self-referral);

2.12.5.2.4. An indication of which Providers are available to Beneficiaries on a self-referral basis;

2.12.5.2.5. How Beneficiaries may obtain directory information in alternate formats that take into consideration the special needs of eligible

individuals including but not limited to, visually-limited, LEP, and LRP eligible individuals;

2.12.5.2.6. The cultural and linguistic capabilities of network Providers, including languages spoken by the network Provider or by skilled medical interpreter at the network Provider's site;

2.12.5.2.7. Network Provider licensing information;

2.12.5.2.8. Whether the network Provider is accessible for people with physical disabilities, including its office, exam room(s) and equipment;

2.12.5.2.9. Whether the Provider is accepting new patients;

2.12.5.2.10. Network Provider access by public transportation;

2.12.5.2.11. Languages other than English spoken by providers or by skilled medical interpreters at the Provider's site, including ASL, and whether translation services are available;

2.12.5.2.12. For behavioral health Providers, qualifications and licensing information, and special experience, skills, and training (i.e., trauma, child welfare, substance use);

2.12.5.2.13. For pharmacies, instructions for the Beneficiaries to contact the ICDS Plan's toll-free Beneficiaries Services telephone line (as described in Section 2.9) for assistance in finding a convenient pharmacy; and

2.12.5.2.14. A description of the roles of the PCP and Trans-Disciplinary Care Management Team and the process by which Beneficiaries select and change PCPs.

2.12.5.3. Upon request from the ICDS Plan, ODM or CMS may authorize exceptions for contracted providers requesting not to be published on the directory.

2.12.5.4. Internet Provider Directory

2.12.5.4.1. The ICDS Plan is required to have an internet-based provider directory available in a format approved by ODM and CMS. This internet directory must allow Beneficiaries to electronically search for ICDS Plan panel Providers based on name, Provider type, and geographic proximity. The internet directory must include providers of both Medicare and Medicaid services. If an ICDS Plan has one internet-based directory for multiple populations, each Provider must include a description of which population they serve.

2.12.5.4.2. The internet directory may be updated at any time to include Providers who are not one of the ODM-required provider types listed on

the charts included herein. ODM-required Providers must be added to the internet directory within one (1) week of submitting the Provider to the MCPN. Providers being deleted from the ICDS Plan's panel must be deleted from the internet directory within one (1) week of notification from the Provider to the ICDS Plan. Providers being deleted from the ICDS Plan's panel must be posted to the internet directory within one (1) week of notification from the Provider to the ICDS Plan of the deletion. ICDS Plans must make changes to the printed Provider/Pharmacy Network Directory to remove deleted providers.

2.12.5.5. Centralized Database. The ICDS Plan must utilize a centralized database which records the special communication needs of all ICDS Plan Beneficiaries (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment) and the provision of related services (i.e., ICDS Plan materials in alternate format, oral interpretation, oral translation services, written translations of ICDS Plan materials, and sign language services).

2.12.5.5.1. This database must include all ICDS Plan Beneficiary primary language information (PLI) as well as all other special communication needs information for ICDS Plan Beneficiaries, as indicated above, when identified by any source including but not limited to ODM, the Managed Care Enrollment Center (MCEC), ICDS Plan staff, providers, and Beneficiaries

2.12.5.5.2. This centralized database must be readily available to ICDS Plan staff and be used in coordinating communication and services to Beneficiaries, including the selection of a PCP who speaks the primary language of an LEP Beneficiary, when such a Provider is available.

2.12.5.6. The ICDS Plan must share specific communication needs information with its Providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable.

2.12.5.7. The ICDS Plan must submit to ODM, upon request, detailed information regarding the ICDS Plan's Beneficiaries with special communication needs, which could include individual Beneficiary names, their specific communication need, and any provision of special services to Beneficiaries (i.e., those special services arranged by the ICDS Plan as well as those services reported to the ICDS Plan which were arranged by the Provider).

2.13. **Financial Requirements**

2.13.1. The Ohio Department of Insurance (ODI) is the agency responsible for licensing managed care plans as Health Insuring Corporations (HICs) pursuant to Section 1751 of the ORC. ODI has primary responsibility for monitoring managed care plan for financial viability, solvency, and stability.

2.13.2. Financial Stability

2.13.2.1. The ICDS Plan must submit the following financial reports to ODM:

2.13.2.1.1. Quarterly and annual ICDS cost reports as designated by ODM. The annual ICDS cost report will require an auditor's certification.

2.13.2.1.2. Copies of all annual and quarterly financial statements and any revision to such copies must be submitted to ODM. For purposes of this contract, "annual financial statement" is the annual "National Association of Insurance Commissioners" (NAIC) statutory filing of the financial condition as adopted and required by the ODI in accordance with Sections 1751.32 and 1751.47 of the Revised Code. The financial statements must include all required health statement filings, schedules and exhibits as stated in the NAIC annual health statement instructions including, but not limited to, the following sections: assets, liabilities, capital and surplus account, cash flow, analysis of operations by lines of business, five-year historical data, and the exhibit of premiums, enrollment and utilization, the designated supplemental exhibits for ICDS and the modified supplemental health care exhibit. The financial statements must be submitted to the ODM even if the ODI does not require the ICDS plans to submit these statements to ODI. An electronic copy of the reports in the NAIC-approved format must be provided to ODM. ICDS plans who are already submitting the financial statements to ODM do not need to submit them twice.

2.13.2.1.3. Annual financial statements for those entities who have an ownership interest totaling five percent (5%) or more in the ICDS Plan or an indirect interest of five percent (5%) or more, or a combination of direct and indirect interest equal to five percent (5%) or more in the ICDS Plan;

2.13.2.1.4. The ICDS Plan must submit to ODM a copy of its audited financial statement as compiled by an independent auditor including the statement of reconciliation with statutory accounting principles as required by ODI in accordance with Section 1751.321 of the Revised Code. The statement must be submitted annually to ODM.

2.13.2.1.5. The ICDS Plan Annual Restated Cost Report for the prior calendar year. The restated cost report shall be audited upon ODM's request.

2.13.2.1.6. ICDS plan physician incentive disclosure statements and other information as required by 42 C.F.R. § 417.

2.13.2.1.7. Notification of requests for information and copies of information released pursuant to a tort action (i.e., third party recovery), as outlined in OAC 5160-58-01.1 and 5160-26-09.1;

2.13.2.1.8. The ICDS plan must submit required reports and additional information, as requested by ODM, as related to their duties and obligations and where needed to assure operation in accordance with all state and federal regulations and requirements. ODM may request reports such as but not limited to; financial, utilization, and statistical reports based on a concern regarding the ICDS Plan's quality of care, delivery of services, fiscal operations or solvency.

2.13.2.1.9. ICDS Plan's must submit ODM-specified reports for the calculation of financial performance measures and standards as outlined in Section 2.13.3.

2.13.2.1.10. *Penalty for noncompliance:* Noncompliance with submission of the above items will result in penalties, as outlined in the Compliance Assessment Policy document.

2.13.3. Financial Performance Measures and Standards

2.13.3.1. The ICDS Plan must meet specific expectations for financial performance. In the interest of administrative simplicity and non-duplication of areas of the 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 plan performance. The five indicators and standards for this Contract period are identified below. The source for each indicator will be the quarterly and annual ICDS Plan cost reports. The report period that will be used to determine compliance will be the annual ICDS Plan cost report.

2.13.3.2. The ODM Methods for ICDS Financial Performance Measures includes information on definitions for and calculations of the following financial performance indicators:

2.13.3.2.1. Indicator: Current Ratio

Standard: Current Ratio is not to fall below 1.00 as determined from the annual ICDS Plan Cost Report submitted to ODM.

2.13.3.2.2. Indicator: Medical Loss Ratio (MLR)

Standard: If an ICDS Plan has an MLR between eighty-five percent (85%) and ninety percent (90%) of the joint Medicare and Medicaid payment to the ICDS Plans, ODM and CMS may require a corrective action plan.

2.13.3.2.3. Indicator: Indicator: Administrative Expense Ratio

Standard: Administrative Expense Ratio is not to exceed fifteen percent (15%), as determined from the annual ICDS Plan cost report submitted to ODM

2.13.3.2.4. Indicator: Overall Expense Ratio

Standard: Overall Expense Ratio is not to exceed one hundred percent (100%) as determined from the annual ICDS Plan cost report submitted to ODM.

2.13.3.2.5. Indicator: Defensive Interval

Standard: The defensive interval is not to fall below thirty (30) days as determined from the annual ICDS Plan cost report submitted to ODM.

2.13.3.3. Penalty for noncompliance:

2.13.3.3.1. Noncompliance with the above standards will result in penalties, as outlined in the Compliance Assessment Policy document. Failure to meet the standards above will result in ODM requiring the ICDS Plan to complete a corrective action plan (CAP) and specifying the date by which compliance must be demonstrated. Failure to meet the standard or otherwise comply with the CAP by the specified date will result in penalties as outlined in Section 2.1.6 unless ODM determines that the deficiency does not potentially jeopardize access to or quality of care or affect the ICDS Plan's ability to meet administrative requirements (e.g., prompt pay requirements). Justifiable reasons for noncompliance may include one-time events (e.g., ICDS Plan investment in information system products).

2.13.3.3.2. If Financial Statements are not submitted to the ODI by the due date, the ICDS Plan continues to be obligated to submit the report to ODM by ODI's originally specified due date unless the ICDS Plan requests and is granted an extension by ODM.

2.13.3.3.3. Failure to submit complete quarterly and annual Financial Statements on a timely basis will be deemed a failure to meet the standards and will be subject to the noncompliance penalties listed above for the indicators above in Section 2.13.3.2 including those outlined in the

Compliance Assessment Policy document. The penalties will take effect at the first of the month following the month in which the determination was made that the ICDS Plan was noncompliant for failing to submit financial reports timely.

2.13.3.3.4. Long-term investments that can be liquidated without significant penalty within 24 hours, which a plan would like to include in cash and short-term investments in the financial performance measures listed in Section 2.13.3.2, must be disclosed in footnotes to the ICDS Plan quarterly and annual cost report. Descriptions and amounts should be disclosed. Please note that "significant penalty" for this purpose is any penalty greater than twenty percent (20%). Also, enter the amortized cost of the investment, the market value of the investment, and the amount of the penalty.

2.13.4. Reinsurance Requirements. Each ICDS Plan must carry reinsurance coverage as required by OAC 5160-58-01.1(A) and 5160-26-09 from a licensed commercial carrier to protect against inpatient-related medical expenses incurred by ICDS Beneficiaries.

2.13.4.1. A copy of the fully-executed reinsurance agreement to provide the specified coverage must be submitted to ODM prior to the effective date of the ICDS Plan Contract.

2.13.4.2. The reinsurance coverage must remain in force during the term of this Contract with ODM and CMS and must contain adequate provisions for Contract extensions.

2.13.4.3. To the extent that the risk for such expenses is transferred to a First Tier, Downstream, or Related Entity the ICDS Plan must provide proof of reinsurance coverage for that First Tier, Downstream, or Related Entity in accordance with the provisions of this paragraph.

2.13.4.4. Each ICDS Plan shall provide written notification to ODM, specifying the dates of admission, diagnosis and estimates of the total claims incurred for all Beneficiaries for which reinsurance claims have been submitted as a part of the ODM ICDS quarterly and annual cost reports.

2.13.4.5. The ICDS Plan must give ODM prior written notice of any proposed changes or modifications in the reinsurance agreements for ODM review and approval. Such notice shall be submitted to ODM thirty (30) days prior to the intended effective date of the proposed change and must include the complete and exact text of the proposed change.

2.13.4.6. The ICDS Plan must provide copies of new or modified reinsurance agreements to ODM within thirty (30) days of execution.

2.13.4.7. In the event of termination of the reinsurance agreement due to insolvency of the ICDS Plan or the reinsurance carrier, the ICDS Plan will be fully responsible for all pending or unpaid claims. Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency must include Beneficiaries as a covered class.

2.13.4.8. Reinsurance requirements for partial-risk arrangements may differ from those specified in this paragraph.

2.13.4.9. The annual deductible or retention amount for such insurance must be specified in the reinsurance agreement and must not exceed $100,000.00, unless ODM has provided the ICDS Plan with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. Except for transplant services, and as provided below, this reinsurance must cover, at a minimum, eighty percent (80%) of inpatient costs incurred by one Beneficiary in one year, in excess of $100,000.00 unless ODM has provided the ICDS Plan with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement.

2.13.4.10. For transplant services, the reinsurance must cover, at a minimum, fifty percent (50%) of inpatient transplant related costs incurred by one Beneficiary in one year, in excess of $100,000.00 unless ODM has provided the ICDS Plan with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement.

2.13.4.11. An ICDS Plan may request a higher deductible amount and/or that the reinsurance cover less than eighty percent (80%) of inpatient costs in excess of the deductible amount, only after the ICDS Plan has one year of Enrollment in Ohio. If the ICDS Plan does not have more than 75,000 Beneficiaries in Ohio, but does have more than 75,000 Beneficiaries between Ohio and other states, ODM may consider alternate reinsurance arrangements. However, depending on the corporate structures of the ICDS Plan, 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, the ODM may consider any or all of the following:

2.13.4.11.1. Whether the ICDS Plan has sufficient reserves available to pay unexpected claims;

2.13.4.11.2. The ICDS Plan's history in complying with financial indicators in Section 2.13.3.2;

2.13.4.11.3. The number of Beneficiaries covered by the ICDS Plan;

2.13.4.11.4. How long the ICDS Plan has been covering Medicaid/Medicare dual eligibles or other Beneficiaries on a full risk basis;

2.13.4.11.5. Risk based capital ratio greater than 2.5 or higher calculated from the last annual ODI financial statement;

2.13.4.11.6. Scatter diagram or bar graph from the last calendar year that shows the number of reinsurance claims that exceeded the current reinsurance deductible and a graph/chart showing the claims history for reinsurance above the previously approved deductible from the last calendar year.

2.13.5. The ICDS Plan's reinsurance coverage must have a deductible that does not exceed $100,000.00 without approval from ODM, or reinsurance coverage for non-transplant services that covers less than eighty percent (80%) of inpatient costs in excess of the deductible incurred by one Beneficiary for one year without approval from ODM. Notification of Regulatory Action.

2.13.5.1. Any ICDS Plan notified by ODI of proposed or implemented regulatory action must report such notification and the nature of the action to ODM no later than one working day after receipt from ODI. ODM may request, and the ICDS Plan must provide, any additional information as necessary to assure continued satisfaction of program requirements. ICDS Plans 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 penalties as outlined in the Compliance Assessment Policy document.

2.14. Data Submissions, Reporting Requirements, and Surveys

2.14.1. General Requirements for Data

2.14.1.1. The ICDS Plan must provide and require its First Tier, Downstream and Related Entities to provide:

2.14.1.1.1. All information CMS and ODM require under the Contract related to the performance of the ICDS Plan's responsibilities, including non-medical information for the purposes of research and evaluation;

2.14.1.1.2. Any information CMS and ODM require to comply with all applicable federal or state laws and regulations; and

2.14.1.1.3. Any information CMS or ODM require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Beneficiary

satisfaction, Beneficiary complaints and Appeals and Enrollment/disenrollment rates.

2.14.2. General Reporting Requirements

2.14.2.1. The ICDS Plan must, in accordance with all applicable MMP reporting requirements:

2.14.2.1.1. Submit reports to ODM;

2.14.2.1.2. Submit reports to CMS in compliance with 42 C.F.R. §§ 422.516, 423.514 and § 438 et. seq.;

2.14.2.1.3. Submit to reports to CMS and ODM as required;

2.14.2.1.4. Submit to CMS and ODM all required data in accordance with the specifications, templates and time frames described in this Contract, unless otherwise directed or agreed to by CMS and ODM;

2.14.2.1.5. Report HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures must be reported consistent with Medicare requirements for HEDIS, plus additional Medicaid measures required by ODM. All existing Part D metrics must be collected as well. Such measures shall include a combined set of core measures that the ICDS Plan must report to CMS and ODM; and

2.14.2.1.6. Submit at the request of CMS or ODM additional ad hoc or periodic reports or analyses of data related to the Contract.

2.14.3. Information Management and Information Systems

2.14.3.1. General: The ICDS Plan shall:

2.14.3.1.1. Maintain Information Systems (Systems) that will enable the ICDS Plan to meet all of ODM's requirements as outlined in this Contract. The ICDS Plan's Systems shall be able to support current ODM requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following ODM standards:

2.14.3.1.1.1. The ODM Unified Process Methodology User Guide;

2.14.3.1.1.2. The User Experience and Style Guide Version 2.0;

2.14.3.1.1.3. Information Technology Architecture Version 2.0; and

2.14.3.1.1.4. Enterprise Web Accessibility Standards 2.0.

2.14.3.1.2. Ensure a secure, HIPAA-compliant exchange of Beneficiary information between the ICDS Plan and any other entity deemed appropriate by ODM. Such files shall be transmitted to ODM through secure FTP, HTS, or a similar secure data exchange as determined by ODM;

2.14.3.1.3. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Beneficiaries and Providers to quickly and easily locate all relevant information. If directed by ODM, the ICDS plan shall establish appropriate links on the ICDS Plan's website that direct users back to the ODM website portal;

2.14.3.1.4. The ICDS Plan shall cooperate with ODM in its efforts to verify the accuracy of all ICDS Plan data submissions to ODM; and

2.14.3.1.5. Actively participate in any ODM Systems Workgroup, as directed by ODM. The Workgroup shall meet in the location and on a schedule determined by ODM.

2.14.3.2. Design Requirements

2.14.3.2.1. The ICDS Plan shall comply with ODM requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

2.14.3.2.2. The ICDS Plan's Systems shall interface with ODM's Legacy MMIS system, ODM's MMIS system, the ODM Virtual Gateway, and other ODM IT architecture.

2.14.3.2.3. The ICDS Plan shall have adequate resources to support the MMIS interfaces. The ICDS Plan shall demonstrate the capability to successfully send and receive interface files, which include, but are not limited to:

2.14.3.2.3.1. Inbound Interfaces

2.14.3.2.3.1.1. Daily Inbound HIPAA 834 Demographic Change File;

2.14.3.2.3.1.2. Care management data;

2.14.3.2.3.1.3. Utilization management data;

2.14.3.2.3.1.4. Provider network data; and

2.14.3.2.3.1.5. Monthly ICDS Plan Provider Directory.

2.14.3.2.3.2. Outbound Interfaces

2.14.3.2.3.2.1. HIPAA 834 Outbound Daily Change File;

2.14.3.2.3.2.2. HIPAA 834 Outbound Full File;

2.14.3.2.3.2.3. HIPAA 820;

2.14.3.2.3.2.4. Historical Utilization Files;

2.14.3.2.3.2.5. Historical prior authorization files;

2.14.3.2.3.2.6. Care management transition files; and

2.14.3.2.3.2.7. TPL Carrier Codes File.

2.14.3.2.3.3. The ICDS Plan shall conform to HIPAA compliant standards for data management and information exchange.

2.14.3.2.3.4. The ICDS Plan shall demonstrate controls to maintain information integrity.

2.14.3.2.3.5. The ICDS Plan shall maintain appropriate internal processes to determine the validity and completeness of data submitted to ODM.

2.14.3.3. System Exchange of Encounter Data

2.14.3.3.1. The ICDS Plan's Systems shall generate and transmit Encounter Data files according to the specifications to be provided in additional guidance for the upcoming reporting year.

2.14.3.4. Accepting and Processing Assessment Data

2.14.3.4.1. System Access Management and Information Accessibility Requirements

2.14.3.4.1.1. The ICDS Plan shall make all Systems and system information available to authorized CMS, ODM and other agency staff as determined by CMS or ODM to evaluate the quality and effectiveness of the ICDS Plan's data and Systems.

2.14.3.4.1.2. The ICDS Plan is prohibited from sharing or publishing CMS or ODM data and information without prior written consent from CMS or ODM.

2.14.3.4.2. System Availability and Performance Requirements

2.14.3.4.2.1. The ICDS Plan shall ensure that its Beneficiary and Provider web portal functions and phone-based functions are available to Beneficiaries and Providers 24 hours a day, seven days a week.

2.14.3.4.2.2. The ICDS Plan shall draft an alternative plan that describes access to Beneficiary and Provider information in the event of system failure. Such plan shall be contained in the ICDS Plan's

Continuity of Operations Plan (COOP) and shall be updated annually and submitted to ODM upon request. In the event of System failure or unavailability, the ICDS Plan shall notify ODM upon discovery and implement the COOP immediately.

2.14.3.4.2.3. The ICDS Plan shall preserve the integrity of Beneficiary-sensitive data that resides in both a live and archived environment.

2.15. Encounter Reporting

2.15.1. The ICDS Plan must meet any diagnosis and/or encounter reporting requirements that are in place for Medicare Advantage plans and have the capability to report all elements as required by ODM in the ODM-specified medium. Furthermore, the ICDS Plan's Systems shall generate and transmit Encounter Data files to CMS according to additional specifications as shall be provided by CMS or ODM and updated from time to time. The IDCS Plan shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified in this Section.

2.15.2. A certification letter must accompany the submission of an encounter data file in the ODM-specified medium. The certification letter must be signed by the ICDS Plan'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 ICDS Plan's CEO or CFO.

2.15.3. CMS and ODM will provide technical assistance to the ICDS Plan for developing the capacity to meet encounter reporting requirements.

2.15.4. Requirements. The ICDS Plan shall:

2.15.4.1. Collect and maintain one hundred percent (100%) Encounter Data for all Covered Services provided to Beneficiaries, including from any sub-capitated sources. Such data must be able to be linked to ODM's eligibility data;

2.15.4.2. Participate in site visits and other reviews and assessments by CMS and ODM, or its designee, for the purpose of evaluating the IDCS Plan's collection and maintenance of Encounter Data;

2.15.4.3. Upon request by CMS, ODM, or their designee, provide medical records of Beneficiaries and a report from administrative databases of the Encounters of such Beneficiaries in order to conduct validation assessments. Such validation assessments may be conducted annually;

2.15.4.4. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by CMS, ODM, or their designee, in

consultation with the ICDS Plan. Such Encounter Data shall include elements and level of detail determined necessary by CMS and the ODM. As directed by CMS and ODM, such Encounter Data shall also include the National Provider Identifier (NPI) of the ordering and referring physicians and professionals and any National Drug Code (NDC);

2.15.4.5. Provide Encounter Data to CMS and ODM on a monthly basis or within time frames specified by CMS and ODM in consultation with the ICDS Plan , including at a frequency determined necessary by CMS and ODM to comply with any and all applicable statutes, rules, regulations and guidance;

2.15.4.6. Submit Encounter Data that is at a minimum standard for completeness and accuracy as defined by CMS. The IDCS Plan must also correct and resubmit denied encounters as necessary;

2.15.4.7. The ICDS Plan shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the Ohio-specific data quality standards to be provided in additional guidance for the upcoming reporting year; and

2.15.4.8. If CMS, ODM, or the IDCS Plan, determines at any time that the Encounter Data is not in accordance with the standards identified by CMS, the IDCS Plan shall:

2.15.4.8.1. Notify CMS and ODM, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

2.15.4.8.2. Submit for CMS and ODM approval, within a time frame established by CMS and ODM, which shall in no event exceed 30 days from the day the ICDS Plan identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

2.15.4.8.3. Implement the CMS and the ODM-approved corrective action plan within a time frame approved by CMS and ODM, which shall in no event exceed thirty (30) days from the date that the IDCS Plan submits the corrective action plan to CMS and ODM for approval; and

2.15.4.8.4. Participate in a validation study to be performed by CMS, ODM, and/or their designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is complete and accurate. The IDCS Plan may be financially liable for such validation study.

2.15.4.9. Report as a voided claim in the monthly Encounter Data submission any claims that the ICDS Plan pays, and then later determines should not have paid.

Section 3. CMS and OHIO Responsibilities

3.1. Contract Management

3.1.1. Administration

3.1.1.1. CMS and ODM will:

3.1.1.1.1. Designate a Contract Management Team (CMT) that will include at least one (1) contract officer from CMS authorized to represent CMS and at least one (1) contract officer from ODM authorized to represent ODM on all aspects of this Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representative and ODM representatives will act as liaisons between the ICDS Plan and CMS and ODM for the duration of the Contract. The CMT will:

3.1.1.1.1.1. Monitor compliance with the terms of the Contract including issuance of joint notices of noncompliance/enforcement.

3.1.1.1.1.2. Coordinate periodic audits and surveys of the ICDS Plan;

3.1.1.1.1.3. Receive and respond to complaints;

3.1.1.1.1.4. Conduct regular meetings with the ICDS Plan;

3.1.1.1.1.5. Coordinate requests for assistance from the ICDS Plan and assign CMS and ODM staff with appropriate expertise to provide technical assistance to the ICDS Plan;

3.1.1.1.1.6. Make best efforts to resolve any issues applicable to the Contract identified by the ICDS Plan, CMS, or ODM; and

3.1.1.1.1.7. Inform the ICDS Plan of any discretionary action by CMS or ODM under the provisions of the Contract;

3.1.1.1.1.8. Coordinate review of marketing materials and procedures; and

3.1.1.1.1.9. Coordinate review of Grievance and Appeals data, and procedures,

3.1.1.1.1.10. Review, approve, and monitor the ICDS Plan's outreach and orientation materials and procedures;

3.1.1.1.1.11. Review, approve, and monitor the ICDS Plan's Complaint and Appeals procedures;

3.1.1.1.1.12. Monitor compliance with all applicable rules and requirements, and issue compliance notices, as appropriate;

3.1.1.1.1.13. Apply one or more of the sanctions provided in Section 5.3, including termination of the Contract in accordance with Section 5.5, if CMS and the ODM determine that the ICDS Plan is in violation of any of the terms of the Contract stated herein;

3.1.1.1.1.14. Conduct site visits as determined necessary by CMS and ODM to verify the accuracy of reported data; and

3.1.1.1.1.15. Coordinate the ICDS Plan's external quality reviews conducted by the external quality review organization.

3.1.2. Performance Evaluation

3.1.2.1. CMS and ODM will, at their discretion:

3.1.2.1.1. Evaluate, through inspection or other means, the ICDS Plan's compliance with the terms of this Contract, including but not limited to, the reporting requirements in Sections 2.14 and 2.15, and the quality, appropriateness, and timeliness of services performed by the ICDS Plan and its Provider Network. CMS and ODM will provide the ICDS Plan with the written results of these evaluations;

3.1.2.1.2. Conduct periodic audits of the ICDS Plan, including, but not limited to an annual independent external review and an annual site visit;

3.1.2.1.3. Conduct annual Beneficiary surveys and provide the ICDS Plan with written results of such surveys; and

3.1.2.1.4. Meet with the ICDS Plan at least semi-annually to assess the ICDS Plan's performance**.**

3.2. Enrollment and Disenrollment Systems

3.2.1. CMS and ODM will maintain systems to provide:

3.2.1.1. Enrollment, disenrollment and Medicare opt-out and opt-in information to the ICDS Plan; and

3.2.1.2. Continuous verification of eligibility status.

3.2.2. Ohio State Enrollment Broker

3.2.2.1. ODM or its designee shall assign a staff person(s) who shall have responsibility to:

3.2.2.1.1. Develop generic materials to assist eligible Beneficiaries in choosing whether to enroll in the Demonstration, which materials shall present the ICDS Plan in an unbiased manner to Beneficiaries eligible to enroll in the ICDS Plans. ODM may collaborate with the ICDS Plan in developing ICDS Plans'-specific materials;

3.2.2.1.2. Present the ICDS Plan in an unbiased manner to Eligible Beneficiaries or those seeking to transfer from one ICDS Plan to another. Such presentation(s) shall ensure that Beneficiaries are informed prior to Enrollment of the following:

3.2.2.1.2.1. The rights and responsibilities of participation in the Demonstration;

3.2.2.1.2.2. The nature of the ICDS Plan's care delivery system, including, but not limited to the Provider Network; and the Comprehensive Assessment, and the Trans-Disciplinary Care Team;

3.2.2.1.2.3. Orientation and other Beneficiary services made available by the ICDS Plan;

3.2.2.1.3. Ensure that Beneficiaries are informed at the time of Enrollment of their right to terminate (opt-out of) their Enrollment from the demonstration voluntarily at any time, unless otherwise provided by federal law or waiver;

3.2.2.1.4. Be knowledgeable about the ICDS Plan's policies, services, and procedures; and

3.2.2.1.5. At its discretion, develop and implement processes and standards to measure and improve the performance of the State Enrollment Broker staff. ODM shall monitor the performance of the State Enrollment Broker.

Section 4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. Capitation Payments

4.1.1.1. CMS and ODM will each contribute to the total capitation payment. CMS and ODM will each make monthly payments to the ICDS Plan for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable federal and Ohio laws, regulations, rules, billing instructions, and bulletins, as amended. The ICDS Plan will receive three (3) monthly payments for each Beneficiary: one amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Parts A/B Component), one amount from CMS reflecting coverage of Medicare Part D services (Medicare Part D Component), and a third amount from ODM reflecting coverage of Medicaid services (Medicaid Component).

4.1.1.2. The Medicare Parts A/B Component will be risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.5. The Part D direct subsidy portion of the Medicare Part D payment will be risk adjusted using the Part D RxHCC Model. The Medicaid Component will utilize the rate cell methodology specified in Section 4.2.1.

4.1.1.3. CMS and ODM will provide the ICDS Plan with a rate report on an annual basis for the upcoming calendar year.

4.1.2. Demonstration Year Dates

4.1.2.1. Capitation rate updates will take place on January 1st of each calendar year. However, savings percentages and quality withhold percentages (see Sections 4.2.3 and 4.3.7) will be applied based on Demonstration Years, as follows:

Demonstration Year	Calendar Dates
1	First effective enrollment date – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

4.2. Capitated Rate Structure

4.2.1. Underlying Rate Structure for the Medicaid Component

4.2.1.1. The State considered the potential risk variation of various subpopulations, financial incentives, and ease of operationalization when it determined the ICDS rate structure. Specifically, the ICDS Enrollment rules, the varying levels of need of the Beneficiaries, the existing Medicaid waivers, and the alignment of

incentives to promote HCBS alternative to nursing facility placement were used to determine the rate structure described within this Section.

4.2.1.2. Regions: Since the choice of ICDS Plans will vary by region and the underlying service utilization varied by region, the ICDS Plan rates will vary by the regions listed in the rate report.

4.2.1.3. The Rate Cells for the Medicaid Component are stratified by Region, and level of care, as follows:

4.2.1.3.1. Community Well: The Community Well category represents those Beneficiaries who do not meet the nursing facility level of care (NFLOC) standard (including the transition rules) as described later in this Section. Within the Community Well category, capitation rates vary by the following age groups: 18–44, 45–64, and 65+.

4.2.1.3.2. Nursing Facility Level of Care

4.2.1.3.3. The NFLOC category represents those Beneficiaries that are eligible for, or who are enrolled in, one of the Ohio Medicaid home- and community-based (HCBS) waiver programs (Assisting Living, Choices, Home Care, PASSPORT, and Transitions II); or are a long-term NF resident with 100 or more consecutive days in a NF (gaps in NF care of fifteen (15) days or less count toward the consecutive day requirement).

4.2.1.3.3.1. The number of NF days is based on Medicare and Medicaid days and includes leave days, which are days when the NFs are paid for a Beneficiary who was discharged from the NF to the hospital but is expected to return to the NF. Once a Medicaid recipient achieves the 100th NF day (regardless of payor), the Beneficiary will be assigned to the NFLOC rate cell in the subsequent month and the plan would then be paid the higher rate associated with this population.

4.2.1.3.3.2. NF residents that have been in a NF for one hundred (100) or more days immediately preceding that Beneficiary's Enrollment in the ICDS Plan program will be classified into the NFLOC rate cell on the first day of Enrollment.

4.2.1.3.3.3. For the NFLOC rate cell, there is a single rating category for each contracting region.

4.2.1.3.3.4. The rates were developed using data from the following NFLOC population groups: Institutional, Community Waiver ages 18–44, Community Waiver ages 45–64, and Community Waiver age 65+.

4.2.1.4. Transitional Rules

4.2.1.4.1. Beneficiaries who had met the criteria for inclusion in the NFLOC rate cell, but later do not, will be transitioned to the Community Well rate cell. The ICDS Plan will continue to receive the NFLOC capitation rate for three (3) full months following the change in categorization. Beginning with the fourth month, the plan will receive the Community Well capitation rate. ICDS Plans are required to submit files documenting beneficiaries' eligibility for the NFLOC rate cell and discharge dates in accordance with specifications provided by ODM.

4.2.1.4.2. Beneficiaries initially in the Community Well category, but who later require care in a NF on a long term basis, will be assigned to the NFLOC rate cell in the month following the Beneficiary's 100th NF day.

4.2.1.4.3. Beneficiaries initially in the Community Well category who move to Community Waiver will be assigned to the NFLOC rate cell in the month following the enrollment in the waiver.

4.2.1.5. Member Enrollment Mix Adjustment (MEMA). To address the potential variations in risk among the participating MyCare Ohio ICDS Plans, the State will be using a MEMA for the Medicaid portion of the capitation. A MEMA will enable the State to better match payment to risk by recognizing the relative risk/cost differences of major and objectively identifiable population groups included in each NFLOC rate cell.

4.2.1.5.1. The selected population groups that will be used for this adjustment are as follows: Institutional, Community Waiver 18–44, Community Waiver 45–64, and Community Waiver 65+. The MEMA will provide more revenue to ICDS Plans that have a greater proportion of high risk/cost Beneficiaries (Institutional and Community Waiver 18–44 Beneficiaries) and, conversely, provide less revenue to ICDS Plans that have a lower proportion of high risk/cost Beneficiaries (Community Waiver 45–64, and Community Waiver 65+). Being budget neutral, the MEMA will not increase or decrease the State's total amount of committed capitation revenue. This feature will be incorporated into the rates starting in the fourth month of MyCare Ohio enrollment for each region.

4.2.1.5.2. Updates to the MEMA will be made effective January and July of each year.

4.2.1.5.3. Relative cost factors are assigned to each of the population groups that comprise the NFLOC rate cell. These relative cost factors are developed by comparing the population group rate to the NFLOC rate. For example, if Institutional Beneficiaries cost $4,000, and the NFLOC rate is $2,000, the relative cost factor is 2.00 ($4,000/$2,000). This same process

is repeated for every population group that comprises the NFLOC. The development of the relative cost factors is region-specific, where the rate for a population group in a region is compared to the NFLOC for that same region.

4.2.1.5.4. The State will analyze actual ICDS Plan Enrollment data at selected points in time and determine the Enrollment mix of each ICDS Plan. The State will multiply each ICDS Plan's Enrollment mix by the respective relative cost factors to determine each ICDS Plan's Beneficiary risk plan factor.

4.2.1.5.5. The State will initially adjust the ICDS Plans' Capitation Rates by the respective Beneficiary risk plan factor applicable to each ICDS Plan. To ensure that the Beneficiary mix adjustments do not increase or decrease the total value of capitation revenue, the State will take a final step to ensure budget neutrality. In this final step, the State will compute the total value of capitation revenue before and after the Beneficiary mix adjustment. If the Beneficiary mix adjusted revenue is greater than or less than the pre-mix adjusted revenue, each of the ICDS Plans' rates will be adjusted by a single budget-neutral factor.

4.2.1.5.6. MEMA factors will be determined on a regional basis, where each of the region's NFLOC rates will be adjusted using the Enrollment attraction patterns specific to that region.

4.2.1.5.7. The use of the MEMA factor is subject to change and may be a temporary feature used for the initial rating periods of the program only until another method for accounting for variations in health risk is introduced or until it is determined that the population in each ICDS Plan has stabilized to a point where further adjustments for risk/acuity differences are deemed unnecessary.

4.2.1.6. Demonstration Beneficiaries

4.2.1.6.1. Enrollment policies, including those for Passive Enrollment, are described in Section 2.3.

4.2.1.6.2. Beneficiaries will have the option to choose not to receive Medicare services through the ICDS Plan.

4.2.2. Underlying Rate Structure for Medicare Component of the Capitation Rate

4.2.2.1. Medicare will pay the ICDS Plan a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.5. Medicare will also pay the ICDS Plan a

monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2. Medicare A/B Component

4.2.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare Fee-For-Service (FFS) standardized county rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population projected to otherwise be in each program in the absence of the Demonstration. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.2.2.2.2. Separate baselines will exist for Beneficiaries meeting the Medicare ESRD criteria. For Beneficiaries with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Beneficiaries in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3-star county rate (benchmark) for the applicable county.

4.2.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as per member per month (PMPM) standardized amounts for each county participating in the Demonstration for each year. Beneficiary risk scores will be applied to the standardized payment rates at the time of payment.

4.2.2.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.2.2.2.5. If a Beneficiary elects to receive the Medicare hospice benefit, the Beneficiary may remain in the ICDS Plan, but will obtain the hospice service through the Medicare FFS benefit and the ICDS Plan would no longer receive the Medicare Parts A/B Component for that Beneficiary as described in this Section. Medicare hospice services and hospice drugs and all other Original Medicare services would be paid for under Medicare FFS. ICDS Plans and providers of hospice services would be required to coordinate these services with the rest of the Beneficiary's care. ICDS Plans would continue to receive the Medicare Part D Component for all non-hospice covered drugs. Election of hospice services does not change the Medicaid Component.

4.2.2.3. Medicare Part D

4.2.2.3.1. The Medicare Part D Component is comprised of the Part D direct subsidy set at the Part D national average monthly bid amount (NAMBA) for the calendar year, as well as the CMS-estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

4.2.2.3.2. The monthly Medicare Part D Component for a Beneficiary can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the Beneficiary, and then adding to this the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.2.3. Aggregate Savings Percentages

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare A/B Component and the Medicaid Component of the capitated rate herein.

4.2.3.1.1. Demonstration Year 1: 1 %

4.2.3.1.2. Demonstration Year 2: 2 %

4.2.3.1.3. Demonstration Year 3: 4 %

4.2.3.2. Except as otherwise specified, rate updates will take place on January 1st of each calendar year.

4.2.3.3. Savings percentages will not be applied to the Part D Component. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

4.2.4. Risk Adjustment Methodology

4.2.4.1. Medicare Parts A/B: The Medicare Parts A/B Component will be risk adjusted based on the risk profile of each Beneficiary. Except as specified in Section 4.2.5, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for the Demonstration.

4.2.4.2. Coding Intensity Adjustment Factor

4.2.4.2.1. In calendar year 2014, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Beneficiaries except as indicated in Section 4.2.5. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Beneficiaries in 2014 with Medicare Advantage experience in 2013. Operationally CMS will still apply the coding intensity adjustment factor to the risk scores but will increase the Medicare A/B FFS baseline for non-ESRD Beneficiaries and Beneficiaries with an ESRD status of functioning graft, to offset this.

4.2.4.2.2. After calendar year 2014, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Beneficiaries.

4.2.4.2.3. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Beneficiaries with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.

4.2.4.3. Medicare Part D: The Medicare Part D national average bid amount will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts will not be risk adjusted.

4.2.5. Medicaid: For the Medicaid Component of the capitated rate, ODM will rely on the methodology described in Section 4.2.1 to account for differences in risk among the eligible population

4.2.6. Medical Loss Ratio (MLR)

4.2.6.1. Medical loss ratio Guarantee: The ICDS Plan has a target MLR of eighty-five percent (85%).

4.2.6.1.1. If an ICDS Plan has an MLR between eighty-five percent (85%) and ninety percent (90%) of the joint Medicare and Medicaid payment to the ICDS Plans, ODM and CMS may require a corrective action plan.

4.2.6.1.2. If an ICDS Plan has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment to the ICDS Plans, the ICDS plan must remit the amount by which the eighty-five percent (85%) threshold exceeds the ICDS Plan's actual MLR multiplied by the total capitation rate revenue of the contract. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis. The MLR calculation shall be determined as set forth below; however, ODM and CMS may adopt NAIC reporting standards and protocols after giving written notice to the ICDS Plan.

4.2.6.2. MLR will be based on the 42 C.F.R. §§ 422.2400 et seq except that the numerator in the MLR calculation will include:

4.2.6.2.1. All Covered Services required in the Demonstration under Section 2.4;

4.2.6.2.2. Any services purchased in lieu of more costly Covered Services and consistent with the objectives of the Demonstration; and

4.2.6.2.3. Care Coordination Expense. That portion of the personnel costs for care coordinators whose primary duty is direct Beneficiary contact that is attributable to this Contract shall be included as a benefit expense. The portion of the personnel costs for ICDS Plan's medical director that is attributable to this Contract shall be included as a benefit expense.

4.2.6.3. The revenue used in the MLR calculation will consist of the Capitation Payments due from ODM and CMS for services provided during the coverage year. Revenue will include amounts withheld pursuant to Section 4.3 regardless of whether the ICDS Plan actually receives the amount in Section 4.3.7.

4.2.6.4. Data Submission. The ICDS Plan shall submit to ODM and CMS, in the form and manner prescribed by ODM and CMS, the necessary data to calculate and verify the MLR within seven (7) months after the end of the coverage year.

4.2.6.5. Medical Loss Ratio Calculation. Within ninety (90) days following the six (6) month claims run-out period following the coverage year, ODM and CMS shall calculate the MLR by dividing the benefit expense by the revenue. The MLR shall be expressed as a percentage rounded to the second decimal point. The ICDS Plan shall have sixty (60) days to review the MLR calculation. Each Party shall have the right to review all data and methodologies used to calculate the MLR.

4.2.6.6. Coverage Year. The first coverage year shall be May 2014 through December 2015. Following December 2015, the coverage year shall be the calendar year. The MLR calculation shall be prepared using all data available

from the coverage year, including IBNP and six (6) months of run-out for benefit expense (excluding sub-capitation paid during the run-out months).

4.3. **Payment Terms**

4.3.1. CMS and ODM will each make monthly, prospective capitation payments to the ICDS Plan. The ODM will categorize Beneficiaries according to the process outlined in Section 4.2. The Medicaid Component for each RC will be the product of the number of Beneficiaries in each category multiplied by the payment rate for that RC, with a MEMA adjustment. The Medicare Parts A/B Component will be the product of the Beneficiary's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate or the Medicare Advantage 3-star county rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Beneficiary's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.3.2. For the Medicaid component of the rate all regions will receive a MEMA adjustment after three (3) months of experience, based on an Enrollment snapshot received in the third month of Passive Enrollment. After the initial application, MEMA refreshes will take place semi-annually, starting January 2015 for all regions as reflected in the table in Section 4.1.2.

4.3.3. Beneficiary contribution to care amounts will be deducted from the Medicaid Component of the monthly capitation payment amount.

4.3.4. Timing of Capitation Payments

4.3.4.1. The timing of the capitation payment will be in accordance with ODM's capitation payment schedule. The payment cycle will be run prospectively and the payment will be released during the current month.

4.3.5. Beneficiary Cost Sharing

4.3.5.1. The ICDS Plan will not charge any premiums for services under this Contract. The ICDS Plan will not assess any cost sharing for services beyond the pharmacy cost sharing described herein.

4.3.5.2. For drugs and pharmacy products (including both those covered by Medicare Part D and Ohio Medicaid), the ICDS Plan will be permitted to charge co-payments to Beneficiaries currently eligible to make such payments. Co-pays charged by the ICDS Plan for Part D and Medicaid drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy, although the ICDS Plan may elect to reduce this cost sharing for all Beneficiaries to encourage medication adherence.

4.3.6. Modifications to Capitation Rates

4.3.6.1. CMS and ODM will jointly notify the ICDS Plan in advance and in writing of any proposed changes to the capitation rates, and the ICDS Plan shall accept such changes as payment in full as described in Section 4.4.

4.3.6.2. Rates will be updated using a similar process for each calendar year. Subject to Section 4.2.2, changes to the Medicare and Medicaid baselines outside of the annual Medicare Advantage and Part D rate announcement will be made only if and when CMS and ODM jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in federal law and/or Ohio policy compared to assumptions about Federal law and/or Ohio law or policy used in the development of baseline estimates; and changes in coding intensity.

4.3.6.3. For changes solely affecting the Medicare program baseline, CMS will update baselines by amounts identified by the independent Office of the Actuary necessary to best effectuate accurate payment rates for each month.

4.3.6.4. Subject to Section 4.2.2, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and ODM to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

4.3.6.5. Changes to the savings percentages will be made if and when CMS and the ODM jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

4.3.7. Quality Withhold Policy for Medicaid and Medicare A/B Components of the Integrated, Risk-Adjusted Rate

4.3.7.1. Under the Demonstration, both CMS and ODM will withhold a percentage of their respective components of the capitation rate, with the exception of the Part D Component amounts. The withheld amounts will be repaid subject to the ICDS Plan's performance consistent with established quality thresholds.

4.3.7.2. CMS and ODM will evaluate the ICDS Plan's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

4.3.7.3. Whether or not the ICDS Plan has met the quality requirements in a given year will be made public.

4.3.7.4. Additional specifications regarding the quality withholds, including more detailed specifications, required thresholds and other information regarding the methodology will be made available in future technical guidance.

4.3.8. Withhold Measures in Demonstration Year 1:

4.3.8.1. Table A-2 below identifies the withhold measures for Demonstration Year 1. Together, these will be utilized for a one percent (1%) withhold.

4.3.8.2. Because Demonstration Year 1 crosses calendar and contract years, the ICDS Plan will be evaluated to determine whether it has met required withhold requirements at the end of both CY 2014 and CY 2015. The determination in CY 2014 will be based solely on those measures that can appropriate be calculated based on actual enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Table A- 2 Quality Withhold Measures for Demonstration Year [1]

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Beneficiaries with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of Beneficiaries on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. In the last 6 months, how often did your health plan's customer service give you the information or help you needed? In the last 6 months, how often did your health plan's customer	AHRQ/CAHPS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
	service treat you with courtesy and respect? In the last 6 months, how often were the forms for your health plan easy to fill out?			
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly Beneficiaries get appointments and care In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	AHRQ/CAHPS	X	
Documentation of care goals	Percent of Beneficiaries with documented discussions of care goals.	CMS/State defined process measure		X
Nursing Facility Diversion Measure	Reporting of the number of Beneficiaries who lived outside the NF during the current measurement year as a proportion of the Beneficiaries who lived outside the NF during the previous year. Nursing Facility Diversion Rate: Numerator: of those Beneficiaries in the denominator, those who did not reside in a NF for more than 100 continuous days during the	State-defined measure		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
	current measurement year. Denominator: Beneficiaries enrolled in ICDS plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any Beneficiary with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.			

4.3.9. Withhold Measures in Demonstration Year 2 and 3

4.3.9.1. The quality withhold will increase to two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Year 3.

4.3.9.2. Payments will be based on performance on the quality withhold measures listed in Table A-3.

Table A-3 Quality Withhold Measures for Demonstration Years 2 and 3

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Plan all-cause readmissions	Percent of Beneficiaries discharged from a hospital stay and who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan Beneficiaries who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental	Percentage of discharges for Beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental	NCQA/HEDIS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
illness	health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.			
Screening for clinical depression and follow-up care	Percentage of Beneficiaries ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
Reducing the risk of falling	Percent of Beneficiaries with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Controlling blood pressure	Percentage of Beneficiaries 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X
Part D medication adherence for oral diabetes medications	Percent of plan Beneficiaries with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	X
Nursing Facility Diversion Measure	Reporting of the number of Beneficiaries who lived outside the NF during the current measurement year as a proportion of the Beneficiaries who lived outside the NF during the previous year. Nursing Facility Diversion Rate: Numerator: of those Beneficiaries in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year.	State-defined measure		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
	Denominator: Beneficiaries enrolled in ICDS Plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any Beneficiaries with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.			
Long Term Care Overall Balance Measure	Reporting of the number of Beneficiaries who did not reside in a NF as a proportion of the total number of Beneficiaries in an ICDS Plan. Numerator: of those Beneficiaries in the denominator, those who did not reside for more than 100 continuous days in a NF during the current measurement year. Denominator: Beneficiaries in an ICDS Plan eleven out of twelve months during the current measurement year. Exclusions: Any Beneficiary with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-defined measure		X

(Note: Part D payments will not be subject to a quality withhold, however the ICDS Plan will be required to adhere to quality reporting requirements that currently exist under Part D.)

4.3.10. American Recovery and Reinvestment Act of 2009

4.3.10.1. All payments to the ICDS Plan are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.3.11. Suspension of Payments

4.3.11.1. ODM may suspend payments to ICDS Plans in accordance with 42 C.F.R. 455.23, *et seq*. as determined necessary or appropriate by ODM.

4.3.12. Transitions between Rating Categories and Risk Score Changes

4.3.12.1. Rating Category Changes

4.3.12.1.1. The Medicaid Component will be adjusted using the methodology described in Section 4.2.1.5.

4.3.12.2. Medicare Risk Score Changes

4.3.12.2.1. Medicare CMS-HCC, CMS-HCC ESRD, and CMS-RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.3.13. Reconciliation

4.3.13.1. CMS and ODM will prescribe a process to reconcile enrollment and capitation payments for the ICDS Plan that will take into consideration the following circumstances: transitions between rating category; retroactive changes in eligibility or rating categories; changes in CMS-HCC and RxHCC risk scores; and changes through new Enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the ICDS Plan. The ICDS Plan may also report any discrepancies to ODM. The ICDS Plan and ODM will work together to resolve these discrepancies.

4.3.14. Medicaid Component Reconciliation

4.3.14.1. The HIPAA 820 (Monthly Remittance Advice) will contain the following: a capitation payment for each Beneficiary listed on the HIPAA 834F, a capitation payment/recoupment for changes listed in the daily HIPAA 834C, any other capitation payment/recoupment, and deliver payment/recoupment from the previous calendar month. Reconciliation for any discrepancies between the HIPAA 834 and HIPAA 820 is due and must be submitted, as instructed by ODM, no later than sixty (60) days after the issuance of the HIPAA 834F. Please reference the Processing Dates for Calendar Year memo that is issued annually.

4.3.14.2. In the event of changes in the processing dates, the due date will be adjusted accordingly. All reconciliation requests must be submitted in the format specified by ODM. ODM may reject reconciliation requests that are submitted after the due date. Reconciliation requests submitted after the due date will be processed at the

discretion of ODM. Recoupments, date of death, duplicative payments made to the same plan due to multiple IDs will always be processed.

4.3.15. Medicare Capitation Reconciliation

4.3.15.1. Medicare capitation reconciliation will comply with prevailing Medicare Advantage and Part D regulations and processes.

4.3.16. Audits/Monitoring

4.3.16.1. CMS and ODM will conduct periodic audits to validate RC assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and ODM.

4.4. Payment in Full

4.4.1. The ICDS Plan must accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

4.4.2. Notwithstanding any contractual provision or legal right to the contrary, the three parties to this Contract (CMS, ODM and the ICDS Plan), for this Demonstration agree there shall be no redress against either of the other two parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

4.4.3. By signing this contract, the ICDS Plan accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the ICDS Plan; and that while data is made available by the Federal Government to the ICDS Plan, any entity participating in the Demonstration must rely on their own resource to project likely experience under the Demonstration.

Section 5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes

5.1.1.1. The ICDS Plan must notify CMS and ODM through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The ICDS Plan must notify CMS and ODM in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Beneficiaries, including but not limited to, reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C. The ICDS Plan must notify CMS and ODM in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

5.1.2. Assignment

5.1.2.1. The ICDS Plan may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and ODM which may be withheld for any reason or for no reason at all.

5.1.3. Independent ICDS Plans

5.1.3.1. The ICDS Plan, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of the federal government or ODM.

5.1.3.2. The ICDS Plan must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated.

5.1.4. Subrogation

5.1.4.1. The ICDS Plan is subject to CMS and/or ODM lien and third-party recovery rights (see OAC 5160-58-01.1 and 5160-26-09.1), it shall subrogate and succeed to any right of recovery of a Beneficiary against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder.

5.1.4.1.1. The ICDS Plan is authorized to ask the Beneficiary to:

5.1.4.1.1.1. Take such action, furnish such information and assistance, and execute such instruments as the ICDS Plan may require to facilitate enforcement of its rights hereunder, and agree to take no action prejudicing the rights and interest of the ICDS Plan; and

5.1.4.1.1.2. Notify the ICDS Plan and authorize the ICDS Plan to undertake such investigation and take such action as the ICDS Plan may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations

5.1.5.1. In accordance with 42 U.S.C. § 1396 u-2(d)(1), the ICDS Plan shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the ICDS Plan's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent of the ICDS Plan's equity or be permitted to serve as a director, officer, or partner of the ICDS Plan.

5.1.6. Disclosure Requirements

5.1.6.1. The ICDS Plan must disclose to CMS and ODM information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The ICDS Plan must obtain federally required disclosures from all network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. 1002.3, and as specified by ODM, including but not limited to obtaining such information through Provider Enrollment forms and credentialing and recredentialing packages. The ICDS Plan must maintain such disclosed information in a manner which can be periodically searched by the ICDS Plan for exclusions and provided to ODM in accordance with this Contract and relevant Ohio and federal laws and regulations. In addition, the ICDS Plan must comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A) if the ICDS Plan is not a federally qualified health maintenance organization under the Public Health Service Act.

5.1.7. Physician Incentive Plans

5.1.7.1. The ICDS Plan may, in its discretion, operate a physician incentive plan only if:

5.1.7.1.1. No single physician is put at financial risk for the costs of treating an Beneficiary that are outside the physician's direct control;

5.1.7.1.2. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Beneficiary; and

5.1.7.1.3. The applicable stop/loss protection, Beneficiary survey, and disclosure requirements of 42 C.F.R. Part 417 are met.

5.1.7.2. The ICDS Plan and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, and 1003 and 42 C.F.R. §438.6(h). The ICDS Plan must submit all information required to be disclosed to CMS and the ODM in the manner and format specified by CMS and the ODM which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.3. In accordance with 42 C.F.R. §417.479, ICDS Plan must maintain copies of the following required documentation and submit to ODM upon request

5.1.7.3.1. A description of the types of physician incentive arrangements the ICDS Plan has in place which indicates whether they involve a withhold, bonus, capitation, or other arrangement. If a physician incentive arrangement involves a withhold or bonus, the percent of the withhold or bonus must be specified;

5.1.7.3.2. 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 may be used by the ICDS Plan for activities such as physician performance improvement projects that include incentive programs or the development of quality improvement;

5.1.7.3.3. A description of the panel size for each physician incentive plan. If Beneficiaries are pooled, then the pooling method used to determine if substantial financial risk exists must also be specified; and

5.1.7.3.4. If more than twenty-five percent (25%) of the total potential payment of a physician/group is at risk for referral services, the ICDS Plan must maintain a copy of the results of the required patient satisfaction survey and documentation verifying that the physician or physician group has adequate stop-loss protection, including the type of coverage (e.g., per member per year, aggregate), the threshold amounts, and any coinsurance required for amounts over the threshold. Upon request by a Beneficiary or a Potential Beneficiary and no later than fourteen (14) calendar days after the request, the ICDS Plan must provide the following information to the Beneficiary: (1) whether the ICDS Plan uses a physician incentive plan that affects the use of referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of the survey results if the ICDS Plan was required to conduct a survey. The information provided by the ICDS Plan must adequately address the Beneficiary's request.

5.1.7.4. The ICDS Plan shall be liable for any and all loss of federal financial participation (FFP) incurred by ODM that results from the ICDS Plan's or its First Tier, Downstream or Related Entity's failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003, however, the ICDS Plan shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Beneficiaries in the ICDS Plan, and the ICDS Plan shall not be liable if it can demonstrate, to the satisfaction of CMS and ODM , that it has made a good faith effort to comply with the cited requirements.

5.1.8. Physician Identifier

5.1.8.1. The ICDS Plan must require each physician providing Covered Services to Beneficiaries under this Contract to have a unique identifier, in accordance with the system established under 42 U.S.C. § 1320d-2(b). The ICDS Plan must provide such unique identifier to CMS and ODM for each of its PCPs in the format and time-frame established by CMS and ODM in consultation with the ICDS Plan.

5.1.9. Timely Provider Payments

5.1.9.1. In accordance with 42 C.F.R. § 447.46, the ICDS Plan must pay ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt, unless the ICDS Plan and its contracted Provider(s) have established an alternative payment schedule that is mutually agreed upon and described in their contract. The clean pharmacy and non-pharmacy claims will be separately measured against the thirty (30) and ninety (90) day prompt pay standards. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the ICDS Plan and delegated claims processing entities.

5.1.9.2. The date of receipt is the date the ICDS Plan receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or date of electronic payment transmission. A claim means a bill from a Provider for health care services that is assigned a unique identifier. A claim does not include an encounter form.

5.1.9.3. 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.

5.1.9.4. *Penalty for noncompliance:* Noncompliance with submission of the above items will result in penalties, as outlined in as outlined in the Compliance Assessment Policy document.

5.1.10. Protection of Beneficiary-Provider Communications

5.1.10.1. In accordance with 42 U.S.C. §1396 u-2(b)(3), the ICDS Plan shall not prohibit or otherwise restrict a clinical First Tier, Downstream, or Related Entity from advising an Beneficiary about the health status of the Beneficiary or medical care or treatment for the Beneficiary's condition or disease, regardless of whether benefits for such care or treatment are provided under the Contract, if the clinical First Tier, Downstream, or Related Entity is acting within the lawful scope of practice.

5.1.11. Protecting Beneficiary from Liability for Payment

5.1.11.1. The ICDS Plan must:

5.1.11.1.1. In accordance with 42 C.F.R. § 438.106, not hold a Beneficiary liable for:

5.1.11.1.1.1. Debts of the ICDS Plan, in the event of the ICDS Plan's insolvency;

5.1.11.1.1.2. Services (other than excluded services) provided to the Beneficiary in the event that the ICDS Plan fails to receive payment from CMS or ODM for such services;

5.1.11.1.1.3. Services (other than excluded services) provided to the Beneficiary in the event the ICDS Plan fails to make payment to the individual or health care provider that furnished the services under a contractual, referral, or other arrangement; or

5.1.11.1.1.4. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Beneficiary if the ICDS Plan had directly provided the services;

5.1.11.1.2. Not charge Beneficiaries coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in this contract.

5.1.11.1.3. Not deny any service provided under this Contract to a Beneficiary for failure or inability to pay any applicable charge;

5.1.11.1.4. Not deny any service provided under this Contract to a Beneficiary who, prior to becoming eligible, incurred a bill that has not been paid; and

5.1.11.1.5. Ensure Provider Network compliance with all Beneficiary payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any member of the ICDS Plan's Provider Network that does not comply with such provisions.

5.1.11.1.6. Ensure that Covered Services will continue to be provided to Beneficiaries during any period of the ICDS Plan's insolvency, for the duration of the period for which payment has been made to the ICDS Plan as well as for inpatient admissions up until discharge.

5.1.12. Moral or Religious Objections

5.1.12.1. The ICDS Plan is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the ICDS Plan objects to the service on moral or religious grounds.

5.1.12.2. If the ICDS Plan elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

5.1.12.2.1. To ODM;

5.1.12.2.2. With its application for a Contract;

5.1.12.2.3. Whenever it adopts the policy during the term of the Contract;

5.1.12.2.4. The information provided must be consistent with the provisions of 42 C.F.R. § 438.10;

5.1.12.2.5. Provided to Potential Beneficiaries before and during Enrollment; and

5.1.12.2.6. Provided to Beneficiaries within ninety (90) days after adopting the policy with respect to any particular service.

5.1.13. Third Party Liability (TPL)

5.1.13.1. General Requirements

5.1.13.1.1. Coordination of Benefits. The ODM shall provide the ICDS Plan with all third party liability insurance information on Beneficiaries where it has verified that third party health liability insurance coverage exists.

5.1.13.1.2. ODM shall refer to the ICDS Plan the Beneficiary's name and pertinent information where ODM knows a Beneficiary has been in an accident or had a traumatic event where a liable third party may exist.

5.1.13.1.3. The ICDS Plan shall:

5.1.13.1.3.1. Designate a TPL benefit coordinator who shall serve as a contact person for benefit coordination issues related to this Contract.

5.1.13.1.3.2. Designate one (1) or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

5.1.13.1.3.3. Perform benefit coordination in accordance with this Section 5.1.13. The ICDS Plan shall work with Ohio via interface transactions with the MMIS system using HIPAA standard formats to submit information with regard to TPL investigations and recoveries.

5.1.13.2. Third Party Health Insurance Information:

5.1.13.2.1. The ICDS Plan shall implement procedures to (1) determine if a Beneficiary has other health insurance except Medicare Part A and B and Medicaid, and (2) identify other health insurance that may be obtained by a Beneficiary using, at a minimum, the following sources:

5.1.13.2.1.1. The HIPAA 834 outbound Enrollment File (for more information on this interface with MMIS and all interfaces, see Section 2.14);

5.1.13.2.1.2. Claims activity;

5.1.13.2.1.3. Point of Service Investigation (customer service, Beneficiary services and Utilization Management); and

5.1.13.2.1.4. Any TPL information self-reported by a Beneficiary.

5.1.13.2.2. At a minimum, such procedures shall include:

5.1.13.2.2.1. If the ICDS Plan also offers commercial policies, the ICDS Plan shall perform a data match within their own commercial plan and ICDS Plan Beneficiary lists. If a Beneficiary is found to also be enrolled in the ICDS Plan's commercial plan, the Beneficiary's information shall be sent to the ODM. ODM shall verify the Beneficiary's Enrollment in MyCare and eligibility status. If ODM determines that the ICDS Plan was correct, ODM will disenroll the Beneficiary retroactive to the effective date of the other insurance; and

5.1.13.2.2.2. Reviewing claims for indications that other insurance may be active (e.g. explanation of benefit attachments or third party payment).

5.1.13.3. Third Party Health Insurance Cost-Avoidance, Pay and Recover Later and Recovery

5.1.13.3.1. Once a Beneficiary is identified as having other health insurance, the ICDS Plan must cost avoid claims for which another insurer may be liable, except in the case of prenatal services per 42 U.S.C. § 1396(a)(25)(E) and 42 C.F.R. § 433.139.

5.1.13.3.2. The ICDS Plan shall perform the following activities to cost-avoid, pay and recover later, or recover claims when other health insurance coverage is available:

5.1.13.3.2.1. Cost-Avoidance. The ICDS Plan shall:

5.1.13.3.2.1.1. On the Daily Inbound Demographic Change File provide all TPL information on the ICDS Plan's Beneficiaries;

5.1.13.3.2.1.2. Pend claims that are being investigated for possible third party health insurance coverage in accordance with ODM's guidelines;

5.1.13.3.2.1.3. Deny claims submitted by a Provider when the claim indicates the presence of other health insurance;

5.1.13.3.2.1.4. Instruct Providers to use the TPL Indicator Form to notify ODM of the potential existence of other health insurance coverage and to include a copy of the Beneficiary's health insurance card with the TPL indicator form if possible; and

5.1.13.3.2.1.5. Distribute TPL indicator forms at the ICDS Plan's Provider orientations.

5.1.13.3.2.2. Pay and Recover Later. The ICDS Plan shall take all actions necessary to comply with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139.

5.1.13.3.2.3. Recovery. The ICDS Plan shall:

5.1.13.3.2.3.1. Identify claims it has paid inappropriately when primary health insurance coverage is identified. Identification will be achieved through data matching processes and claims analyses;

5.1.13.3.2.3.2. Implement policies and procedures and pursue recovery of payments made where another payer is primarily liable; and

5.1.13.3.2.3.3. Develop procedures and train staff to ensure that Beneficiaries who have comprehensive third party health insurance are identified and reported to ODM.

5.1.13.3.2.4. Reporting

5.1.13.3.2.4.1. Semi-annually, the ICDS Plan shall report to ODM the following:

5.1.13.3.2.4.1.1. Other Insurance – the number of referrals sent by the ICDS Plan on the Inbound Demographic Change File, and the number of Beneficiaries identified as having TPL on the monthly HIPAA 834 inbound Enrollment file;

5.1.13.3.2.4.1.2. Pay and Recover Later – the number and dollar amount of claims that were paid and recovered later consistent with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139;

5.1.13.3.2.4.1.3. Cost avoidance – the number and dollar amount of claims that were denied by the ICDS Plan due to the existence of other health insurance coverage on a semi-annual basis, and the dollar amount per Beneficiary that was cost avoided on the denied claim; and

5.1.13.3.2.4.1.4. Recovery - Claims that were initially paid but then later recovered by the Contractor as a result of identifying coverage under another health insurance plan, on a semi-annual basis, and the dollar amount recovered per Beneficiary from the other liable insurance carrier or Provider.

5.1.13.3.2.5. Accident and Trauma Identification and Recovery Identification

5.1.13.3.2.5.1. Cost Avoidance and Recovery. The ICDS Plan shall recover or cost-avoid claims where a Beneficiary has been involved in an accident or lawsuit.

5.1.13.3.2.5.2. Claims Editing and Reporting. The ICDS Plan shall utilize the following claims editing and reporting

procedures to identify potential accident and/or other third party liability cases:

5.1.13.3.2.5.2.1. Claims Reporting – Specific diagnosis ranges that may indicate potential accident and casualty cases;

5.1.13.3.2.5.2.2. Provider Notification – Claims where providers have noted accident involvement;

5.1.13.3.2.5.2.3. Patient Questionnaires – Questionnaires will be sent to Beneficiaries who are suspected of having suffered an injury as a result of an accident; and

5.1.13.3.2.5.2.4. Questionnaires will be based on a predetermined diagnosis code range.

5.1.13.3.2.5.3. Medical Management. The ICDS Plan shall identify any requested medical services related to motor vehicle accidents, or work related injuries, and refer these claims to the recoveries specialist for further investigation.

5.1.13.3.2.6. Reporting. On a semi-annual basis, the ICDS Plan will provide the ODM with cost avoidance and recovery information on accidents and trauma case.

5.2. Confidentiality

5.2.1. Statutory Requirements

5.2.1.1. The ICDS Plan understands and agrees that CMS and ODM may require specific written assurances and further agreements regarding the security and privacy of protected health information (PHI) that are deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 C.F.R., parts 160 and 164. The ICDS Plan further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under ORC 5160.45 and any other applicable Ohio law or regulations and in accordance with any data-sharing or other agreements that the ICDS Plan has with ODM that protects and safeguards the confidentiality of health or personal data of Beneficiaries. The ICDS Plan represents and warrants that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable Ohio and federal laws. The ICDS Plan is required to design, develop, or operate a system of records on Beneficiaries, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2. Personal Data

5.2.2.1. The ICDS Plan must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

5.2.3. Data Security

5.2.3.1. The ICDS Plan must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Beneficiary names. The ICDS Plan must put all appropriate administrative, technical, and physical safeguards in place before the Contract start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. § 164.530(c).

5.2.3.2. The ICDS Plan shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Contract. The ICDS Plan 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 C.F.R. Part 431 Subpart F and ORC 5160.45, as well as 42 C.F.R. 2.12 and ORC 5119.27 when applicable. The terms of this Section shall be included in any subcontracts executed by the ICDS Plan for services under this Contract. The ICDS Plan agrees to implement procedures to ensure that in the process of coordinating care, each Beneficiary's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. The ICDS Plan agrees, certifies and affirms that HHS, US Comptroller General or representatives will have access to books, documents, and other business records of the ICDS Plan.

5.2.4. Return of Personal Data

5.2.4.1. The ICDS Plan must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or ODM in whatever form it is maintained by the ICDS Plan. Upon the termination or completion of this Contract, the ICDS Plan shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or ODM will destroy such data or material.

5.2.5. Research Data

5.2.5.1. The ICDS Plan must seek and obtain prior written authorization from CMS and ODM for the use of any data pertaining to this Contract for research or any other purposes not directly related to the ICDS Plan's performance under this Contract.

5.2.6. Additional Ohio-Specific Provisions:

5.2.6.1. Destruction of Personal Data. Upon termination of this Contract and at the request of ODM, the ICDS Plan shall return to ODM or destroy all PHI in its possession stemming from this Agreement, and shall not keep copies of the PHI except as requested by ODM or required by law. If the ICDS Plan, its agent(s), or First Tier, Downstream, or Related Entities (s) destroy any PHI, then the ICDS Plan will provide to ODM documentation evidencing such destruction. Any PHI retained by the ICDS Plan shall continue to be extended the same protections set forth in this Section.

5.2.6.2. For any PHI received regarding a Beneficiary referred to ICDS Plan by ODM who does not enroll in the ICDS Plan, the ICDS Plan must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable state and federal Privacy

and security laws including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time. The ICDS Plan shall also adhere to standards described in OMB Circular No. A-130, Appendix III-Security of Federal Automated Information Systems and NIST Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" while in possession of all PHI.

5.3. General Terms and Conditions

5.3.1. Applicable Law

5.3.1.1. All applicable law is hereby incorporated into this Contract by reference.

5.3.2. Sovereign Immunity

5.3.2.1. Nothing in this Contract will be construed to be a waiver by the State of Ohio or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives

5.3.3.1. Nothing in this Contract shall be interpreted to require a Beneficiary to execute an advance directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

5.3.4. Loss of Licensure

5.3.4.1. If, at any time during the term of this Contract, the ICDS Plan or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the ICDS Plan's facilities or loss of necessary Federal or Ohio approvals, the ICDS Plan must immediately report such loss to CMS and ODM. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification

5.3.5.1. The ICDS Plan shall indemnify and hold harmless CMS, ODM, the federal government, and Ohio from and against any and all liability, loss, damage, costs, or expenses which CMS and or ODM may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the ICDS Plan, any person employed by the ICDS Plan, or any of its First Tier, Downstream, or Related Entities..

5.3.6. Prohibition against Discrimination

5.3.6.1. In accordance with 42 U.S.C. § 1396 u-2(b)(7), the ICDS Plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the ICDS Plan's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or Ohio law, solely on the basis of such license or certification. Pursuant to 42 C.F.R. § 438.12(a)(1), if the ICDS Plan declines to include individuals or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision. This Section does not prohibit the ICDS Plan from including Providers in its Provider Network to the extent necessary to meet the needs of the ICDS Plan's Beneficiaries, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the ICDS Plan, or from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

5.3.6.2. If a complaint or claim against the ICDS Plan is presented to ODM for handling discrimination complaints, the ICDS Plan must cooperate with in the investigation and disposition of such complaint or claim.

5.3.7. Anti-Boycott Covenant

5.3.7.1. During the time this Contract is in effect, neither the ICDS Plan nor any affiliated company, as hereafter defined, should participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended. Without limiting such other rights as it may have, CMS and ODM will be entitled to rescind this Contract in the event of noncompliance with this Section. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one percent (51%) of the ownership interests of the ICDS Plan.

5.3.8. Information Sharing

5.3.8.1. During the course of a Beneficiary's Enrollment or upon transfer or termination of Enrollment, whether voluntary or involuntary, and subject to all applicable federal and Ohio laws, the ICDS Plan must arrange for the transfer, at no cost to CMS, ODM or the Beneficiary, of medical information regarding such Beneficiary to any subsequent Provider of medical services to such Beneficiary, as may be requested by the Beneficiary or such Provider or directed by CMS and ODM, the Beneficiary, regulatory agencies of Ohio, or the United States Government. With respect to Beneficiaries, the ICDS Plan must provide, upon reasonable request of ODM, a copy of said Beneficiary's medical records in a timely manner.

5.3.9. Other Contracts

5.3.9.1. Nothing contained in this Contract must be construed to prevent the ICDS Plan from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the ICDS Plan must provide CMS and ODM with a complete list of such plans and services, upon request. CMS and ODM will exercise discretion in disclosing information that the ICDS Plan may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or ODM from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

5.3.10. Counterparts

5.3.10.1. This Contract may be executed simultaneously in two (2) or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.11. Entire Contract

5.3.11.1. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein.

5.3.12. No Third-Party Rights or Enforcement

5.3.12.1. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.13. Corrective Action Plan

5.3.13.1. If, at any time, CMS and/or ODM reasonably determine that the ICDS Plan is deficient in the performance of its obligations under the Contract, CMS and/or ODM may require the ICDS Plan to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and/or ODM will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The ICDS Plan must promptly and diligently implement the corrective action plan as approved by CMS and/or ODM. Failure to implement the corrective action plan may subject the ICDS Plan to termination of the Contract by CMS or ODM or other sanctions as described in Section 5.3.14. The requirements surrounding a Corrective Action Plan hereunder do not preclude CMS or ODM from pursuing other sanctions or related actions as allowed by federal and/or state law, including OAC 5160-58-01.1 and 5160-26-10, with respect to the ICDS Plan, individually or collectively for actions or omissions under this Contract. Additional guidance regarding the imposition of a corrective

action plan by ODM or on the application of sanctions can be found in the Compliance Assessment Policy document maintained by ODM and available on ODM's website.

5.3.14. Sanctions

5.3.14.1. In addition to termination under Section 5.5, CMS and ODM, individually or collectively, may, impose any or all of the sanctions hereunder upon any of the events below; provided, however, that CMS and ODM will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified and will individually not impose duplicative sanctions for the same actions or omissions. Sanctions may be imposed if the ICDS Plan:

5.3.14.1.1. Fails substantially to provide Covered Services required to be provided under this Contract to Beneficiaries;

5.3.14.1.2. Imposes charges on Beneficiaries in excess of any permitted under this Contract;

5.3.14.1.3. Discriminates among Beneficiaries or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.14.1.4. Misrepresents or falsifies information provided to CMS, ODM, Beneficiaries, or its Provider Network;

5.3.14.1.5. Fails to comply with requirements regarding physician incentive plans in Section 5.1.7;

5.3.14.1.6. Fails to comply with federal or Ohio statutory or regulatory requirements related to this Contract;

5.3.14.1.7. Violates restrictions or other requirements regarding marketing;

5.3.14.1.8. Fails to comply with QI requirements consistent with Section 2.11

5.3.14.1.9. Fails to comply with any corrective action plan required by CMS and/or ODM;

5.3.14.1.10. Fails to comply with financial solvency requirements;

5.3.14.1.11. Fails to comply with reporting requirements; or

5.3.14.1.12. Fails to comply with any other requirements of this Contract.

5.3.14.2. Such sanctions may include but are not necessarily limited to:

5.3.14.2.1. Intermediate sanctions consistent with 42 C.F.R. § 438.702;

5.3.14.2.2. Financial penalties consistent with 42 C.F.R. § 438.704 and/or Ohio law, including OAC rule 5160-26-10;

5.3.14.2.3. The appointment of temporary management to oversee the operation of the ICDS Plan in those circumstances set forth in 42 U.S.C. §1396 u-2(e)(2)(B);

5.3.14.2.4. Suspension of Enrollment (including assignment of Beneficiaries);

5.3.14.2.5. Suspension of payment to the ICDS Plan;

5.3.14.2.6. Disenrollment of Beneficiaries; and

5.3.14.2.7. Suspension of marketing.

5.3.14.3. If CMS or ODM have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the ICDS Plan has not successfully implemented an approved corrective action plan in accordance with Section 5.3.13 herein**,** CMS and ODM may:

5.3.14.3.1. Require the ICDS Plan to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and ODM; or

5.3.14.3.2. Require the ICDS Plan to change the manner or method in which the ICDS Plan ensures the performance of such contractual responsibility.

5.3.14.4. Any sanctions undertaken under this Section 5.3.14 by ODM or CMS, individually or collectively, are not meant to be exclusive to any other actions or sanctions permitted ODM or CMS under federal or state law. Additional guidance on the application of sanctions by ODM can be found in the Compliance Assessment Policy document maintained by ODM and available on ODM's website.

5.3.15. Additional Administrative Procedures

5.3.15.1. CMS and ODM may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The ICDS Plan must comply with all such program memoranda as may be issued from time to time.

5.3.16. Effect of Invalidity of Clauses

5.3.16.1. If any clause or provision of this Contract is in conflict with any federal or Ohio law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

5.3.17. Conflict of Interest

5.3.17.1. Neither the ICDS Plan nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and ODM with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, CMS and ODM require that neither the ICDS Plan nor any First Tier, Downstream, or Related Entity has any financial, legal, contractual or other business interest in any entity performing ICDS Plan enrollment functions for ODM, the CST Enrollment Vendor, and any First Tier, Downstream, or Related Entity(ies) .

5.3.17.2. 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 ICDS Plan, the Chief of the Bureau of Managed Care at ODM, or other ODM employee who exercises any functions or responsibilities in connection with the review or approval of this Contract or provision of services under this Contract 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.

5.3.17.3. The ICDS Plan represents, warrants, and certifies that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws. The ICDS Plan further represents, warrants, and certifies that neither the ICDS Plan nor any of its employees will do any act or any omission that is inconsistent with such laws specifically ORC § 102.03, 2921.42, and 2921.43.

5.3.17.4. The ICDS Plan hereby covenants that the ICDS Plan, its officers, Beneficiaries and employees of the ICDS Plan, shall not, prior to the completion of the work under this Contract, 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 Contract. The ICDS Plan shall periodically inquire of its officers, members and employees concerning such interests.

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

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

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

5.3.18. Insurance for ICDS Plan's Employees

5.3.18.1. The ICDS Plan must agree to maintain at the ICDS Plan's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide CMS and ODM with certification of same upon request. The ICDS Plan, and its professional personnel providing services to Beneficiaries, must obtain and maintain appropriate professional liability insurance coverage. The ICDS Plan must, at the request of CMS or ODM, provide certification of professional liability insurance coverage, at the levels and limits of coverage as deemed appropriate by CMS and/or ODM.

5.3.19. Key Personnel

5.3.19.1. If the ICDS Plan wishes to substitute another individual for the individual identified in Section 2.2, the ICDS Plan must notify CMS and the ODM immediately and provide the name and résumé, if requested, of a suitable replacement. CMS and the ODM may request an opportunity to interview the person. If CMS and the ODM are not reasonably satisfied that the proposed replacement has ability and experience comparable to the originally approved

personnel, CMS and the ODM will notify the ICDS Plan within ten (10) Business Days after receiving the résumé and completing any interview..

5.3.19.2. If CMS and the ODM are concerned that the person identified in Section 2.2 is not performing responsibilities required by this Contract, CMS and the ODM will inform the ICDS Plan of this concern. The ICDS Plan must investigate said concerns promptly, take any actions the ICDS Plan reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify CMS and the ODM of such actions. If the ICDS Plan's actions fail to ensure full compliance with the terms of this Contract, as determined by CMS and the ODM, the corrective action provisions in Section 5.3.13 may be invoked by CMS and the ODM.

5.3.20. Waiver

5.3.20.1. The ICDS Plan, CMS, or ODM shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the ICDS Plan, CMS, or ODM in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and ODM of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract

5.3.21. Section Headings

5.3.21.1. The headings of the Sections of this Contract are for convenience only and will not affect the construction hereof.

5.3.22. Other ODM Terms and Conditions

5.3.22.1. MBE/EDGE. Pursuant to the Gubernatorial Executive Order 2008-13S, ODM encourages the ICDS Plan to purchase goods and services under this Contract from certified Minority Business Enterprise (MBE) and Encouraging Diversity, Growth, and Equity (EDGE) vendors whenever possible. The ICDS Plan agrees to encourage any of its subgrantees or First Tier, Downstream or Related Entities to purchase goods and services from certified MBE and EDGE vendors.

5.3.23. Non-Exclusion:

5.3.23.1. The ICDS Plan certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or State department or agency, and is not currently barred or suspended from contracting with ODM.

5.3.23.2. If at any time during the term of this Contract, the ICDS Plan becomes barred, suspended, or excluded from participation in this transaction, the ICDS Plan shall, within thirty (30) days after becoming barred, suspended or excluded, provide to the ODM a written description of each offense causing the exclusion, the date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence complete.

5.3.24. Lobbying:

5.3.24.1. The ICDS Plan certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of the ICDS Plan, to any Person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

5.3.24.2. If any funds other than federally appropriated funds have been paid or will be paid to any Person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the ICDS Plan shall complete and submit a, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at the ICDS Plan's request from ODM's Office of Fiscal Operations.

5.3.24.3. The ICDS Plan shall require that the language of this certification be included in the award document for sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

5.3.24.4. This certification is a material representation of fact upon which reliance was placed when this Contract was executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any Person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

5.3.24.5. The ICDS Plan certifies that it has accurately completed the certification.

5.4. **Record Retention, Inspection, and Audit**

5.4.1. The ICDS Plan must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten years.

5.4.2. The ICDS Plan must make the records maintained by the ICDS Plan and its Provider Network), as required by CMS and ODM and other regulatory agencies, available to CMS and ODM and its agents, designees or ICDS Plans or any other authorized representatives of the State of Ohio or the United States Government, or their designees or ICDS Plans, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the ICDS Plan.

5.4.3. The ICDS Plan further agrees that the Secretary of the U.S., Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the Ohio Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the ICDS Plan and its First Tier, Downstream and Related Entities that pertain to: the ability of the ICDS Plan to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.4. The ICDS Plan must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Beneficiaries, and any additional relevant information that CMS or ODM may require, in a manner that meets CMS and ODM's record maintenance requirements.

5.4.5. The ICDS Plan must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and ODM, and their designees to inspect, evaluate, and audit records through ten years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and Ohio requirements.

5.5. **Termination of Contract**

5.5.1. Termination without Prior Notice

5.5.1.1. In the event the ICDS Plan substantially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or ODM programs, CMS or ODM may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract.

5.5.1.2. Without limiting the above, if CMS or ODM determine that participation of the ICDS Plan in the Medicare or ODM program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Beneficiaries or compromise the integrity of the Medicare or ODM program, CMS or ODM, without prior notice, may immediately terminate this Contract, suspend the ICDS Plan from participation, withhold any future payments to the ICDS Plan, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary enrollment into any ICDS Plan, and shall be taken upon a finding by CMS or ODM that the ICDS Plan has not achieved and demonstrated a readiness in Ohio that will allow for the safe and efficient provision of Medicare-Medicaid services to Beneficiaries.

5.5.1.3. This contract is subject to the Contract Disputes Act of 1978, as amended (41 U.S.C. § 601-613). Failure of the parties to this Contract to reach agreement on any request for equitable adjustment, claim, Appeal or action arising under or relating to this Contract shall be a dispute to be resolved in accordance with the clause at 48 C.F.R. § 52.233-1, Disputes, which is hereby incorporated into this Contract by reference. The ICDS Plan shall proceed diligently with performance of this Contract, pending final resolution of any dispute arising under the Contract.

5.5.1.4. Prior to submitting a claim pursuant to the Contract Disputes Act, the ICDS Plan may request review by CMS if it believes errors have been made in the claims analyses conducted eighteen (18) months into the Demonstration to determine the amount to be deferred for the last year of the Demonstration, and again at the end of the Demonstration as part of the reconciliation process. Request for review should be submitted to the Director of the Office of Research, Development, and Information (ORDI) and must be submitted in writing. Nothing in this provision is intended to waive the ICDS Plan's responsibility to comply with the time limitations in 48 C.F.R. § 52.233-1, Disputes (incorporated by reference) or the Contract Disputes Act.

5.5.1.5. United States law will apply to resolve any claim of breach of this Contract.

5.5.2. Termination with Prior Notice

5.5.2.1. CMS or ODM may terminate this Contract without cause upon no less than 180 days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.7, the ICDS Plan may choose to non-renew prior to the end of each term pursuant to 42 C.F.R. § 422.506(a), except that in Demonstration Year 1 the ICDS Plan may choose to non-renew the contract as of December 31, 2014 provided the ICDS plan gives notice before August 1, 2014 and may terminate the contract by mutual consent of CMS and ODM at any time pursuant to 42 C.F.R. § 422.508. In considering

requests for termination under 42 C.F.R. § 422.508, CMS and ODM will consider, among other factors, financial performance under this Contract in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and ODM prior to their use.

5.5.2.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers ICDS Plan termination of this Contract with prior notice as described in Section 5.5.2.1 and non-renewal of this Contract as described in Section 5.7 to be circumstances warranting special consideration, and will not prohibit the ICDS Plan from applying for new Medicare Advantage contracts or Service Area expansions for a period of two years due to termination.

5.5.3. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.5.3.1. Termination for Cause

5.5.3.1.1. Any party may terminate this Contract upon 90 days' notice due to a material breach of a provision of this Contract unless CMS or ODM determines that a delay in termination would pose an imminent and serious risk to the health of the Beneficiaries enrolled with the ICDS Plan or the ICDS Plan experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Beneficiaries, whereby CMS or ODM may expedite the termination.

5.5.3.1.2. Pre-termination Procedures. Before terminating a contract under 42 C.F.R. §422.510 and §438.708, the ICDS Plan may request a pre-termination hearing or develop and implement a corrective action plan. CMS or ODM must:

5.5.3.1.3. Give the ICDS Plan written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least 30 calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.3.1.4. Notify the ICDS Plan of its Appeal rights as provided in 42 C.F.R. §422 Subpart N and §438.710.

5.5.3.2. Termination due to a Change in Law-

5.5.3.2.1. In addition, CMS or ODM may terminate this Contract upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

5.5.4. Continued Obligations of the Parties

5.5.4.1. In the event of termination, expiration, or non-renewal of this Contract, or if the ICDS Plan otherwise withdraws from the Medicare or ODM programs, the ICDS Plan shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Beneficiary at the time of such termination or withdrawal until the Beneficiary has been disenrolled from the ICDS Plan; provided, however, that CMS and ODM will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

5.5.4.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.4.2.1. CMS and ODM will be responsible for notifying all Beneficiaries covered under this Contract of the date of termination and the process by which those Beneficiaries will continue to receive care. If the ICDS Plan elects to terminate or not renew the Contract, or if the contract is mutually terminated by the ICDS Plan, CMS and ODM, the ICDS Plan will be responsible for notifying all Beneficiaries and the general public, in accordance with federal and Ohio requirements;

5.5.4.2.2. The ICDS Plan must promptly return to CMS and ODM all payments advanced to the ICDS Plan for Beneficiaries after the effective date of their disenrollment; and

5.5.4.2.3. The ICDS Plan must supply to CMS and ODM all information necessary for the payment of any outstanding claims determined by CMS and ODM to be due to the ICDS Plan, and any such claims will be paid in accordance with the terms of this Contract.

5.6. Order of Precedence

5.6.1. The following documents are incorporated into and made a part of this Contract:

5.6.1.1. Appendices A through I to this Contract;

5.6.1.2. Memorandum of Understanding, a document between CMS and the ODM Regarding a Federal-Ohio Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Beneficiaries (December 12, 2012);

5.6.1.3. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year;

5.6.1.4. any special conditions that indicate they are to be incorporated into this Contract and which are signed by the parties; and

5.6.1.5. Applicable federal law, including but not limited to Titles 18 and 19 of the Social Security Act, and all relevant regulations and guidance thereunder and all relevant State law and regulations and guidance, including but not limited to, OAC Chapter 5160-58, the MyCare Ohio Provider Agreement, and the Compliance Methodology, are hereby incorporated by reference as part of this Contract, having the full force and effect as if specifically restated herein.

5.6.2. In the event of any conflict among the documents that are a part of this Contract, the order of priority to interpret the Contract shall be as follows:

5.6.2.1. the Contract terms and conditions;

5.6.2.2. Appendices A through I to this Contract;

5.6.2.3. any special conditions that indicate they are to be incorporated into this Contract and that are signed by the parties; and

5.6.2.4. Memorandum of Understanding Between CMS and ODM (formerly a part of ODJFS) of December 12, 2012.

5.6.2.5. As a condition for approval of the demonstration the prior approval of the State's Section 1915 (b) waiver # OH-0014 and Section 1915 (c) waiver # OH-1035 are required.

5.6.2.6. Applicable Federal laws, regulations and guidance promulgated thereunder.

5.6.2.7. Applicable State law, regulations and guidance promulgated thereunder.

5.6.2.8. State contractual requirements, including but not limited to the Medicaid Provider Agreement.

5.7. **Contract Term**

5.7.1. This Contract shall be in effect starting on the date on which all Parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2017, so long as the ICDS Plan has not provided CMS and ODM with a notice of intention not to renew, pursuant to 42 C.F.R. §422.506 or Section 5.5, above.

5.7.2. At the discretion of CMS and upon notice to the Parties, this Contract may be terminated, or the effectuation of the Contract Operational Start Date may be delayed, if ODM has not received all necessary approvals from CMS or, as provided in Section 2.2.1.3 of this Contract, if the ICDS Plan is determined not to be ready to participate in the MyCare Ohio Program.

5.7.3. ODM may not expend Federal funds for, or award Federal funds to, the ICDS Plan until ODM has received all necessary approvals from CMS. ODM may not make payments to ICDS Plan by using Federal funds, or draw Federal Medical Assistance Payment (FMAP) funds, for any services provided, or costs incurred, by ICDS Plan prior to the later of the approval date for any necessary State Plan and waiver authority, the Readiness Review approval, or the Contract Operational Start Date.

5.8. **Amendments**

5.8.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or Ohio statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto.

5.9. **Written Notices**

5.9.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

5.9.1.1. To CMS:

Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard, S3-13-23
Baltimore, MD 21244

5.9.1.2. To the State:

Ohio Department of Medicaid
50 West Town Street
4th Floor
Columbus, OH 43215

Copies to:

General Counsel
Medicaid Director

5.9.1.3. To the ICDS Plan:

To: Insert Name of Individual or Department.

Insert Mailing Address- No P.O. Boxes

Copies to:

Names, Titles, Email Addresses, and Physical Addresses

Section 6. Signatures

In Witness Whereof, CMS, ODM, and the ICDS Plan have caused this Agreement to be executed by their respective authorized officers:

Insert Name & Title [ICDS Plan]	Date

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In Witness Whereof, CMS, ODM, and the ICDS Plan have caused this Agreement to be executed by their respective authorized officers:

Verlon Johnson Associate Regional Administrator Centers for Medicare & Medicaid Services United States Department of Health and Human Services	Date
Danielle R. Moon, J.D., M.P.A Director Medicare Drug & Health Plan Contract Administration Group Centers for Medicare & Medicaid Services United States Department of Health and Human Services	Date

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In Witness Whereof, CMS, ODM, and the ICDS Plan have caused this Agreement to be executed by their respective authorized officers:

John B. McCarthy, Director	Date
Ohio Department of Medicaid	

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Section 7. Appendices

Appendix A. Covered Services

1. Medical Necessity. The ICDS Plan shall provide services to Beneficiaries as follows:

Section 1.1 Authorize, arrange, coordinate, and provide to Beneficiaries all Medically Necessary Covered Services as specified in Section 2.4, in accordance with the requirements of the Contract.

Section 1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A. Prevent, diagnose, or treat health impairments;

B. Attain, maintain, or regain functional capacity.

Section 1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Beneficiary.

Section 1.4 Not deny authorization for a Covered Service that the Beneficiary or the Provider demonstrates is Medically Necessary.

Section 1.5 The ICDS Plan may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of Utilization Management, provided that the furnished services can reasonably be expected to achieve their purpose. The ICDS Plan 's Medical Necessity guidelines must, at a minimum, be:

A. Developed with input from practicing Physicians in the ICDS Plan's Service Area;

B. Developed in accordance with standards adopted by national accreditation organizations;

C. Section 1 and developed in accordance with the definition of Medical Necessity in Section 2;

D. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

E. Evidence-based, if practicable; and

F. Applied in a manner that considers the individual health care needs of the Beneficiary.

Section 1.6 Offer and provide to all Beneficiaries any and all non-medical programs and services specific to Beneficiaries for which the ICDS Plan has received the ODM's approval.

2. Covered Services. The ICDS Plan agrees to provide Beneficiaries access to the following Covered Services:

Section 2.1 All services provided under Ohio State Plan services, excluding Habilitation and targeted case management for individuals with developmental disabilities.

Section 2.2 Home and Community Based Waiver Services for individuals eligible for and enrolled in the 1915 (c) HCBS Waiver.

Section 2.3 All services provided under Medicare Part A.

Section 2.4 All services provided under Medicare Part B.

Section 2.5 All services provided under Medicare Part D.

Section 2.6 Particular pharmacy products that are covered by ODM and may not be covered under Medicare Part D, including:

A. Agents when used for the symptomatic relief of cough and colds: cough suppressants only.
B. Prescription vitamins and mineral products, except prenatal vitamins and fluoride.
C. Nonprescription drugs: cough suppressants, vitamins, antacids, antidiarrheals, stool softeners, laxatives, wound protectants, artificial tears.

Section 2.7 Any plan supplemental services/benefits offered by the ICDS Plan through its annual plan benefit package submissions.

3. Cost-sharing for Covered Services

Section 3.1 Except as described below, cost-sharing of any kind is not permitted in this Demonstration.

Section 3.2 Cost sharing for Part D drugs.

A. Co-pays charged by ICDS Plans for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

B. The ICDS Plan may establish lower cost-sharing for prescription drugs than the maximum allowed.

Section 3.3 Cost sharing for Medicaid Services.

A. For Medicaid services ICDS Plans may elect to implement co-payments for Medicaid covered drugs, but will not charge cost sharing to Beneficiaries above levels established under the Part D Low Income Subsidy.

B. ICDS Plans may waive Medicaid cost sharing, subject to applicable regulatory and legal requirements and limitations.

C. Beneficiaries who are residents of NFs or enrolled in the 1915(c) waiver, may be required to contribute to the cost of NF care that amount of patient liability established by the County Department of Jobs and Family Services.

4. Limitations on Covered Services.

Section 4.1 – Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).

Appendix B. Beneficiary Rights

The ICDS Plan must have written policies regarding the Beneficiary rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Beneficiaries. Beneficiaries must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Beneficiary rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. 422 Subpart C, and the Ohio Memorandum of Understanding (MOU). Specifically, Beneficiaries must be guaranteed:

A. The right to be treated with dignity and respect.
B. The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
C. The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
D. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Beneficiary's condition, functional status, and language needs.
E. The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
F. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
G. Access to an adequate network of primary and specialty providers who are capable of meeting the Beneficiary's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
H. The right to receive a second opinion on a medical procedure and have the Contractor pay for the second opinion consultation visit.
I. The right to choose another ICDS plan and network Provider from within the plan's network at any time, including a Medicare plan outside of the demonstration, and have that choice be effective the first calendar day of the following month.
J. The right to have a voice in the governance and operation of the integrated system, provider or health plan, as detailed in this three-way contract.
K. The right to participate in all aspects of care and to exercise all rights of appeal. Beneficiaries have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Beneficiaries must:
    a. Receive an in-person Comprehensive Assessment upon enrollment in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical,

behavioral, wellness and prevention domains, an evaluation of the Beneficiary's strengths and weaknesses, and a plan for managing and coordination Beneficiary's care. Beneficiaries, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.

b. Receive complete and accurate information on his or her health and Functional Status by the interdisciplinary team.
c. Be provided information on all program services and health care options, including available treatment options and alternatives, and the risks, benefits, and consequences of treatment or non-treatment, presented in a culturally appropriate manner, taking in to consideration Beneficiary's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
    i. Before enrollment.
    ii. At enrollment.
    iii. At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.
d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.
e. Have advance directives explained and to establish them, if the participant so desires, in accordance with 42 C.F.R. §§489.100 and 489.102.
f. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
g. Be afforded the opportunity to file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

L. The right to receive medical and non-medical care from a team that meets the Beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.
M. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
N. Each Beneficiary is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the ICDS Plan and its providers or the Ohio Agency treat the Beneficiary.
O. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and , the right to receive notice of any significant change in the information provided in the

Orientation materials at least 30 days prior to the intended effective date of the change. See 42 C.F.R. §§ 438.10 for G and H.

P. The right to be protected from liability for payment of any fees that are the obligation of the ICDS Plan.

Q. The right not to be charged any cost sharing for Medicare Parts A and B services.

Appendix C. Relationship With First Tier, Downstream, And Related Entities

A. ICDS Plan shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on ICDS Plan's behalf related to the operation of the Medicare-Medicaid plan are in compliance with 42 C.F.R. §§ 422.504, 423.505, and 438.6(l) and OAC 5160-58-01.1 and 5160-26-05.

B. ICDS Plan shall ensure that the provisions of this Appendix shall supersede any previous or subsequent agreements between ICDS Plans and First Tier, Downstream and Related Entities, to the extent that any provisions herein conflict with any other agreed-to requirements.

C. ICDS Plan shall specifically ensure:
   1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and
   2. HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

D. ICDS Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
   1. Beneficiary protections that include prohibiting providers from holding an Beneficiary liable for payment of any fees that are the obligation of the ICDS Plan;
   2. Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the ICDS Plan's contractual obligations to CMS and ODM;
   3. Language that specifies the delegated activities and reporting requirements;
   4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, ODM or the ICDS Plan determine that such parties have not performed satisfactorily;
   5. Language that specifies the performance of the parties is monitored by the ICDS Plan on an ongoing basis and the ICDS Plan may impose corrective action as necessary;
   6. Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Beneficiary Privacy and confidentiality of Beneficiary health records; and
   7. Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and Ohio laws, regulations and CMS instructions.

E. ICDS Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:
   1. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the ICDS Plan; or
   2. The credentialing process will be reviewed and approved by the ICDS Plan and the ICDS Plan must audit the credentialing process on an ongoing basis.

F. ICDS Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must include language that the ICDS Plan retains the right to approve, suspend, or terminate any such arrangement.

G. ICDS Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the ICDS Plan shall provide a written statement to a provider of the reason or reasons for termination with cause.

H. ICDS Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:

1. Language that the ICDS Plan is obligated to pay contracted medical providers under the terms of the contract between the ICDS Plan and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the ICDS Plan and the relevant medical provider;
2. Language that services are provided in a culturally competent manner to all Beneficiaries, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
3. Language that medical providers abide by all Federal and Ohio laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;
4. Language that medical providers ensure that medical information is released in accordance with applicable Federal or Ohio law, or pursuant to court orders or subpoenas;
5. Language that medical providers maintain Beneficiary records and information in an accurate and timely manner;
6. Language that medical providers ensure timely access by Beneficiaries to the records and information that pertain to them; and
7. Language that Beneficiaries will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Beneficiaries.
8. Language that clearly describes the medical providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.
9. Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Beneficiaries as patients unless the same limitations apply to all commercially insured Beneficiaries.
10. Language that prohibits the ICDS Plan from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:
    (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the ICDS Plan's health benefit plans as they relate to the needs of such provider's patients; or

(b) Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by the ICDS Plan for services provided to the patient.

11. Language that states the provider is not required to indemnify the ICDS Plan for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the ICDS Plan based on the ICDS Plan's management decisions, utilization review provisions or other policies, guidelines or actions.
12. Language that states the ICDS Plan shall require Providers to comply with the ICDS Plan's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.
13. Language that states the ICDS Plan shall notify Providers in writing of modifications in payments, modifications in Covered Services or modifications in the ICDS Plan's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided thirty (30) days before the effective date of such modification unless such other date for notice is mutually agreed upon between the ICDS Plan and the Provider or unless such change is mandated by CMS or the ODM without thirty (30) days prior notice.
14. Language that states all First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003. Specifically, Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers do not include incentive plans that include a specific payment made directly or indirectly to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services furnished to an individual Beneficiary. Contractor shall ensure its First Tier, Downstream and Related Entities comply with all Beneficiary payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any member of the Contractor's First Tier, Downstream and Related Entities that does not comply with such provisions.
15. Language that states that Providers shall not bill patients for charges for Covered Services other than pharmacy co-payments, if applicable.
16. Language that states that no payment shall be made by the ICDS Plan to a Provider for a Provider Preventable Condition; and

I. ICDS Plan shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers do not include incentive plans that include a specific payment to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services and;

1. The provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.
2. The ICDS Plan shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.

J. Language that prohibits the ICDS Plan from imposing a financial risk on medical Providers for the costs of medical care, services or equipment provided or authorized by another Physician or health care Provider such contract must include specific provisions with respect to the following:
   1. Stop-loss protection;
   2. Minimum patient population size for the physician or physician group; and
   3. Identification of the health care services for which the physician or physician group is at risk.

K. The ICDS Plan shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

L. Nothing in this Section shall be construed to restrict or limit the rights of the ICDS Plan to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

Appendix D. Part D Addendum

ADDENDUM TO CAPITATED FINANCIAL ALIGNMENT CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and <<CONTRACT_NAME>>, the State of Ohio acting by and through the Ohio Department of Medicaid (hereinafter referred to as "ODM") , and a Medicare-Medicaid managed care organization (hereinafter referred to as ICDS Plan) agree to amend the contract <<CONTRACT_ID>> governing ICDS Plan's operation of a Medicare-Medicaid plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") to include this addendum under which ICDS Plan shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

Article I

Voluntary Medicare Prescription Drug Plan

A. ICDS Plan agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application* , released on March 29, 2012 (hereinafter collectively referred to as "the addendum"). ICDS Plan also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to ICDS Plan consistent with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on ICDS Plan. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to ICDS Plan, ODM, and CMS.

Article II
Functions to be Performed by ICDS Plan

A. ENROLLMENT

1. ICDS Plan agrees to enroll in its Medicare-Medicaid plan only Medicare-Medicaid eligible Beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have elected to enroll in ICDS Plan's Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. ICDS Plan agrees to provide the required prescription drug coverage as defined under 42 C.F.R. § 423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. § 423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. ICDS Plan also agrees to provide Part D benefits as described in ICDS Plan's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. ICDS Plan agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. § 423.505(b)(25).

C. DISSEMINATION OF PLAN INFORMATION

1. ICDS Plan agrees to provide the information required in 42 C.F.R. § 423.48.

2. ICDS Plan acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the contract year as provided in 42 C.F.R. § 423.505(o).

3. ICDS Plan certifies that all materials it submits to CMS and ODM under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. ICDS Plan agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. ICDS Plan agrees to address complaints received by CMS against the ICDS Plan as required in 42 C.F.R. § 423.505(b)(22) by:

   (a) Addressing and resolving complaints in the CMS complaint tracking system; and

   (b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

E. APPEALS AND GRIEVANCES

ICDS Plan agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. ICDS Plan acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to ICDS Plan through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO ICDS PLAN

ICDS Plan and CMS and ODM agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

G. PLAN BENEFIT SUBMISSION AND REVIEW

If ICDS Plan intends to participate in the Part D program for the next program year, ICDS Plan agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, ODM and ICDS Plan may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. ICDS Plan acknowledges that failure to submit a timely plan benefit package under this Section may affect the ICDS Plan's ability to offer a plan, pursuant to the provisions of 42 C.F.R. § 422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. ICDS Plan agrees to comply with the coordination requirements with Ohio Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.

2. ICDS Plan agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. § 423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. ICDS Plan agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and ODM (as defined in Appendix H) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and ODM that meet the requirements of 42 C.F.R. § 423.120.

2. ICDS Plan agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. § 423.124.

3. ICDS Plan agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. § 423.100), and long-term care pharmacies (as defined in 42 C.F.R. § 423.100) according to 42 C.F.R. § 423.505(b)(17).

4. ICDS Plan agrees to contract with any pharmacy that meets ICDS Plan's reasonable and relevant standard terms and conditions according to 42 C.F.R. § 423.505(b)(18).

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

ICDS Plan agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. § 423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

ICDS Plan agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

ICDS Plan agrees to afford its Beneficiaries protection from liability for payment of fees that are the obligation of ICDS Plan in accordance with 42 C.F.R. § 423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. ICDS Plan agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. ICDS Plan shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on ICDS Plan's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. § 423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

ICDS Plan must provide certifications in accordance with 42 C.F.R. § 423.505(k).

O. ICDS PLAN REIMBURSEMENT TO PHARMACIES

1. If ICDS Plan uses a standard for reimbursement of pharmacies based on the cost of a drug, ICDS Plan will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. ICDS Plan will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

3. ICDS Plan must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to ICDS Plan for reimbursement.

Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

ICDS Plan agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

ICDS Plan agrees to submit information to CMS according to 42 C.F.R. §§ 423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS AND ODM LICENSE FOR USE OF ICDS PLAN FORMULARY

ICDS Plan agrees to submit to CMS and ODM the ICDS Plan's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

A. ICDS Plan agrees to comply with the confidentiality and Beneficiary record accuracy requirements specified in 42 C.F.R. § 423.136.

B. ICDS Plan agrees to enter into a business associate agreement with the entity with which CMS

has contracted to track Medicare Beneficiaries' true out-of-pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2014. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. § 423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 C.F.R. §423.507, ICDS Plan will be determined qualified to renew this addendum annually only if—

   (a) ICDS Plan has not provided CMS or ODM with a notice of intention not to renew in accordance with Article VII of this addendum, and

   (b) CMS or ODM has not provided ICDS Plan with a notice of intention not to renew.

2. Although ICDS Plan may be determined qualified to renew its addendum under this Article, if ICDS Plan, CMS, and ODM cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article VI
Nonrenewal of Addendum

A. NONRENEWAL BY ICDS PLAN

ICDS Plan may non-renew this addendum in accordance with 42 C.F.R. § 423.507(a).

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. § 423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. § 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 C.F.R. § 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article IX
Termination of Addendum by ICDS Plan

A. ICDS Plan may terminate this addendum only in accordance with 42 C.F.R. § 423.510.

B. If the addendum is terminated under Section A of this Article, ICDS Plan must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

Article X
Relationship between Addendum and Capitated Financial Alignment Contract

A. ICDS Plan acknowledges that, if it is a Capitated Financial Alignment ICDS Plan, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the ICDS Plan's Capitated Financial Alignment contract in the event that such non-renewal or termination prevents ICDS Plan from meeting the requirements of 42 C.F.R. § 422.4(c), in which case the ICDS Plan must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment contract to which this document is an addendum.

C. In the event that ICDS Plan's Capitated Financial Alignment contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate. In such an event, ICDS Plan, ODM and CMS shall provide notice to Beneficiaries and the public as described in this contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 C.F.R. Part 423, ICDS Plan shall be subject to sanctions and civil money penalties.

Article XII
Severability

Severability of the addendum shall be in accordance with 42 C.F.R. § 423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

ICDS Plan agrees that it has not altered in any way the terms of the ICDS Plan addendum presented for signature by CMS. ICDS Plan agrees that any alterations to the original text ICDS Plan may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

ICDS Plan agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. § 423.505(j).

D. CMS AND ODM APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

ICDS Plan agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and ODM approval to begin ICDS Plan marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and ODM systems to process enrollment applications (or contracting with an entity qualified to perform such functions on ICDS Plan's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, ICDS Plan must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), ICDS Plan agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. ICDS Plan agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. § 423.505(b)(23).

Appendix E. Data Use Attestation

The ICDS Plan shall restrict its use and disclosure of Medicare data obtained from CMS and ODM information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and ODM to administer. The ICDS Plan shall only maintain data obtained from CMS and ODM information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and ODM to administer. The ICDS Plan (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or ODM, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the ICDS Plan contracted with CMS and ODM.

The ICDS Plan further attests that it shall limit the use of information it obtains from its Medicare-Medicaid Beneficiaries to those purposes directly related to the administration of such plan. The ICDS Plan acknowledges two exceptions to this limitation. First, the ICDS Plan may provide its Medicare-Medicaid Beneficiaries information about non-health related services after obtaining consent from the Beneficiaries. Second, the ICDS Plan may provide information about health-related services without obtaining prior Beneficiary consent, as long as the ICDS Plan affords the Beneficiary an opportunity to elect not to receive such information.

CMS may terminate the ICDS Plan's access to the CMS data systems immediately upon determining that the ICDS Plan has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Beneficiaries beyond the scope for which CMS and the ODM have authorized under this agreement. A termination of this data use agreement may result in CMS or ODM terminating the ICDS Plan's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an ICDS Plan. This agreement shall remain in effect as long as the ICDS Plan remains an ICDS Plan sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or ODM make available to the general public on their websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits ICDS Plan (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

Appendix F. Model File & Use Certification Form

Pursuant to the contract between the Centers for Medicare & Medicaid Services (CMS), the State of Ohio, acting by and through the Ohio Department of Medicaid (ODM), and (insert organization name), hereafter referred to as the ICDS Plan, governing the operations of the following health plan: (insert health plan name and Contract number), the ICDS Plan hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or ODM to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 CFR § 422.2260 – § 422.2276 and 42 CFR § 422.111 for the ICDS Plan and the Medicare Marketing Guidelines.

I agree that CMS or ODM may inspect any and all information including those held at the premises of the ICDS Plan to ensure compliance with these requirements. I further agree to notify CMS and ODM immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the ICDS Plan.

_____
Signature

_____
Name & Title <CEO, CFO, or designee able to legally bind the organization>
On behalf of

_____
Name of ICDS Plan

_____
Date

Appendix G. Medicare Mark License Agreement

THIS AGREEMENT is made and entered into <<DATE>>

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

<<CONTRACT_NAME>> (hereinafter "Licensee"),
with offices located at <<ADDRESS>>.

CMS Contract ID: <<CONTRACT_ID>>

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning <DATE>.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2014, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2014, this agreement shall be renewable for

successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

Appendix H. Service Area

[The approved Service Area for each ICDS Plan.]