

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

This Provider Agreement (herein Provider Agreement or Agreement) is entered into between the State of Ohio, The Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal offices are located in the City of Columbus, County of Franklin, State of Ohio, and INSERT CORPORATE NAME, MyCare Ohio Plan (hereinafter referred to as MCOP), an Ohio corporation, whose principal office is located in the city of INSERT CITY, County of INSERT COUNTY, State of Ohio.

The MCOP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and agrees to operate as prescribed by Chapter 5160-58 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time.

The MCOP is an entity eligible to enter into a provider agreement in accordance with 42 CFR (Code of Federal Regulations) 438.6 and is engaged in the business of providing comprehensive health care services as defined in 42 CFR 438.2 through the managed care program for the Medicaid-Medicare eligible population described in OAC rule 5160-58-02(A) and any other Medicaid eligible populations authorized by the Centers for Medicare and Medicaid Services (CMS).

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

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

ODM, as the single state agency designated to administer the Medicaid program under Section 5162.03 of the ORC and Title XIX of the Social Security Act, desires to obtain MCOP services for the benefit of certain Medicaid recipients. In so doing, the MCOP has provided and will

continue to provide proof of the MCOP's capability to provide quality services, efficiently, effectively and economically during the term of this Agreement.

This Provider Agreement is a contract between ODM and the undersigned MCOP, provider of medical assistance, pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCOP agrees to provide comprehensive Medicaid services through the managed care program as provided in Chapter 5160-58 of the OAC, assuming the risk of loss, and at all times complying with federal and state laws and regulations, federal and state Medicaid program requirements, and other requirements as specified by ODM. This includes without limitation Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

#### ARTICLE I - GENERAL

- A. ODM enters into this Agreement in reliance upon the MCOP's representations that it has the necessary expertise and experience to perform its obligations hereunder, and the MCOP represents and warrants that it does possess such necessary expertise and experience.
- B. The MCOP agrees to communicate with the Chief of the Bureau of Managed Care (BMC) (hereinafter referred to as BMC) or his or her designee as necessary in order for the MCOP to assure its understanding of the responsibilities and satisfactory compliance with this Provider Agreement.
- C. The MCOP agrees to furnish its staff and services as necessary for the satisfactory performance of the services as enumerated in this Provider Agreement.
- D. ODM may, from time to time as it deems appropriate, communicate specific instructions and requests to the MCOP concerning the performance of the services described in this Provider Agreement. Upon such notice and within the designated time frame after receipt of instructions, the MCOP shall comply with such instructions and fulfill such requests to the satisfaction of the department. It is expressly understood by the parties that these instructions and requests are for the sole purpose of performing the specific tasks requested to ensure satisfactory completion of the services described in this Provider Agreement, and are not intended to amend or alter this Provider Agreement or any part thereof.

#### ARTICLE II - TIME OF PERFORMANCE

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

#### ARTICLE III - REIMBURSEMENT

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

#### ARTICLE IV - RELATIONSHIP OF PARTIES

- A. ODM and the MCOP agree that, during the term of this Agreement, the MCOP shall be engaged with ODM solely on an independent contractor basis, and neither the MCOP nor its personnel shall, at any time or for any purpose, be considered as agents, servants or employees of ODM or the state of Ohio. The MCOP shall therefore be responsible for all the MCOP's business expenses, including, but not limited to, employee's wages and salaries, insurance of every type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any.
- B. The MCOP agrees to comply with all applicable federal, state, and local laws in the conduct of the work hereunder.
- C. ODM retains the right to ensure that the MCOP's work is in conformity with the terms and conditions of this Agreement.
- D. Except as expressly provided herein, neither party shall have the right to bind or obligate the other party in any manner without the other party's prior written consent.

#### ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS

- A. In accordance with the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) and other applicable federal requirements, no officer, member or employee of the MCOP, the Chief of BMC, or other ODM employee who exercises any functions or responsibilities in connection with the review or approval of this Provider Agreement or provision of services under this Provider Agreement shall, prior to the completion of such services or reimbursement, acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with, or would compromise in any manner or degree the discharge and fulfillment of his or her functions and responsibilities with respect to the carrying out of such services. For purposes of this article, "members" does not include individuals whose sole connection with the MCOP is the receipt of services through a health care program offered by the MCOP.
- B. The MCOP represents, warrants, and certifies that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws. The MCOP further represents, warrants, and certifies that neither the MCOP nor any of its employees will do any act or omit any action that is inconsistent with such laws.

- C. The MCOP hereby covenants that the MCOP, its officers, members and employees of the MCOP, shall not, prior to the completion of the work under this Agreement, voluntarily acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of his or her functions and responsibilities under this Provider Agreement. The MCOP shall periodically inquire of its officers, members and employees concerning such interests.
- D. Any such person who acquires an incompatible, compromising or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, shall immediately disclose his or her interest to ODM in writing. Thereafter, he or she shall not participate in any action affecting the services under this Provider Agreement, unless ODM shall determine in its sole discretion that, in the light of the personal interest disclosed, his or her participation in any such action would not be contrary to the public interest. The written disclosure of such interest shall be made to: Chief, BMC, ODM.
- E. No officer, member or employee of the MCOP shall promise or give to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. The MCOP, along with its officers, members and employees, understand and agree to take no action, or cause ODM or its employees to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws including without limitation those provisions found in Chapter 102 and Chapter 2921 of the ORC.
- F. The MCOP hereby covenants that the MCOP, its officers, members and employees are in compliance with section 102.04 of the ORC and that if MCOP 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.

#### ARTICLE VI - NONDISCRIMINATION OF EMPLOYMENT

- A. The MCOP agrees that in the performance of this Provider Agreement or in the hiring of any employees for the performance of services under this Provider Agreement, the MCOP shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry, discriminate against any individual in the employment of an individual who is qualified and available to perform the services to which the Provider Agreement relates.
- B. The MCOP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the Provider Agreement on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry.
- C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5160-58, the MCOP agrees to hold all subcontractors and persons acting on behalf of the

MCOP in the performance of services under this Provider Agreement responsible for adhering to the requirements of paragraphs (A) and (B) above and shall include the requirements of paragraphs (A) and (B) above in all subcontracts for services performed under this Provider Agreement, in accordance with OAC rules 5160-58-01.1 and 5160-26-05.

#### ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION

- A. The MCOP agrees that all records, documents, writings or other information produced by the MCOP under this Provider Agreement and all records, documents, writings or other information used by the MCOP in the performance of this Provider Agreement shall be treated in accordance with OAC rules 5160-58-01.1 and 5160-26-06 and must be provided to ODM, or its designee, if requested. The MCOP must maintain an appropriate record system for services provided to members. The MCOP must retain all records in accordance with 45 CFR 74.53.
- B. All information provided by the MCOP to ODM that is proprietary shall be held to be strictly confidential by ODM. Proprietary information is information which, if made public, would put the MCOP at a disadvantage in the market place and trade of which the MCOP is a part [see ORC Section 1333.61(D)]. The MCOP agrees to expressly indicate by marking the top or bottom of each individual record containing information the MCOP deems proprietary or trade secret, regardless of media type (CD-ROM, Excel file etc.) prior to its release to ODM. Upon request from ODM, the MCOP agrees to promptly notify ODM in writing of the nature of the proprietary information including all reasonable evidence regarding the nature of the proprietary information in records submitted to ODM. The MCOP also agrees to provide for the legal defense of all proprietary information submitted to ODM. ODM shall promptly notify the MCOP in writing or via email of the need to legally defend the proprietary information such that the MCOP is afforded the opportunity to adequately defend such information. Failure to provide such prior notification or failure to legally defend the proprietary nature of such information is deemed to be a waiver of the proprietary nature of the information, and a waiver of any right of the MCOP to proceed against ODM for violation of this Provider Agreement or of any proprietary or trade secret laws. Such failure shall also be deemed a waiver of trade secret protection in that the MCOP will have failed to make efforts that are reasonable under the circumstances to maintain the information's secrecy. ODM will make the final determination of whether any or all of the information identified by the MCOP is proprietary or a trade secret. The provisions of this Article are not self-executing.
- C. The MCOP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Provider Agreement. The MCOP agrees to be bound by the same standards of confidentiality that apply to the employees of ODM and the State of Ohio, including without limitation the confidentiality requirements found in 42 CFR Part 431 Subpart F and ORC 5160.45, as well as 42 C.F.R. 2.12 and ORC 5119.27, as applicable. The terms of this section shall be included in any subcontracts executed by the MCOP for services under this Provider Agreement. The MCOP must

implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

- D. The MCOP agrees, certifies and affirms that HHS, US Comptroller General or representatives will have access to books, documents, and other business records of the MCOP.
- E. All records relating to performance, under or pertaining to this Provider Agreement will be retained by the MCOP in accordance to the appropriate records retention schedule. The appropriate records retention schedule for this Provider Agreement is for a total period of eight (8) years. For the initial three (3) years of the retention period, the records must be stored in a manner and place that provides readily available access. If any records are destroyed prior to the date as determined by the appropriate records retention schedule, the MCOP agrees to pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.
- F. The MCOP agrees to retain all records in accordance with any litigation holds that are provided to them by ODM, and actively participate in the discovery process if required to do so, at no additional charge. Litigation holds may require the MCOP to keep the records longer than the approved records retention schedule. The MCOP will be notified by ODM when the litigation hold ends and retention can resume based on the approved records retention schedule. If the MCOP fails to retain the pertinent records after receiving a litigation hold from ODM, the MCOP agrees to pay to ODM all damages, costs and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.
- G. The MCOP shall promptly notify ODM of any legal matters and administrative proceedings including, but not limited to, litigation and arbitration, which involve or otherwise pertain to the activities performed pursuant to this Provider Agreement and any third party. In the event that the MCOP possesses or has access to information and/or documentation needed by ODM with regard to the above, the MCOP agrees to cooperate with ODM in gathering and providing such information and/or documentation to the extent permissible under applicable law.

#### ARTICLE VIII - NONRENEWAL AND TERMINATION

- A. This Provider Agreement may be terminated, pursuant to Section 5.5 of the Three-Way or by ODM or the MCOP upon written notice in accordance with the applicable rule(s) of the OAC, with termination to occur at the end of the last day of the termination month. If the Three-Way is terminated, and ODM decides to enter into a new Provider Agreement with the MCOP, MCOP shall be required to enter into a new Provider Agreement with ODM that shall begin the day after the termination of the Three-Way. By executing this Agreement, MCOP expressly agrees to be bound by this provision of the Agreement. If the option to enter into a new Provider Agreement per this Section is exercised, the MCOP

will be provided a copy of the proposed new Provider Agreement for review prior to execution. The terms of the new Provider Agreement will not be unconscionable or capricious and the parties agree to negotiate in good faith.

- B. Subsequent to receiving a notice of termination from ODM, the MCOP beginning on the effective date of the termination, shall cease provision of services on the terminated activities under this Provider Agreement; terminate all subcontracts relating to such terminated activities, take all necessary or appropriate steps to limit disbursements and minimize costs, and comply with the requirements specified in this Provider Agreement, as of the date of receipt of notice of termination describing the status of all services under this Provider Agreement.
- C. In the event of termination under this Article, the MCOP shall be entitled to request reconciliation of reimbursements through the final month for which services were provided under this Provider Agreement, in accordance with the reimbursement provisions of this Provider Agreement. The MCOP agrees to waive any right to, and shall make no claim for, additional compensation against ODM by reason of such suspension or termination.
- D. In the event of termination under this Article, MCOP shall return all records in their native format relating to cost, work performed, supporting documentation for invoices submitted to ODM, and copies of all materials produced under or pertaining to this Provider Agreement.
- E. ODM may, in its sole discretion, terminate or fail to renew this Provider Agreement if the MCOP or MCOP's subcontractors violate or fail to comply with the provisions of this Agreement or other provisions of law or regulation governing the Medicaid program. Where ODM proposes to terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the OAC with respect to ODM's suspension, termination or refusal to enter into a provider agreement may apply Pursuant to ORC 5164.38, the MCOP does not have the right to request an adjudication hearing under Chapter 119 of the ORC to challenge any action taken or decision made by ODM with respect to entering into or refusing to enter into a provider agreement with the MCOP pursuant to section 5167.10 of the Revised Code.
- F. The MCOP understands that availability of funds to fulfill the terms of this Provider Agreement is contingent on appropriations made by the Ohio General Assembly and the United States government for funding the Medicaid program. If sufficient funds are not available from the Ohio General Assembly or the United States government to make payments on behalf of a specific population (Aged, Blind, Disabled, Covered Families and Children, or Adult Extension) to fulfill the terms of this Provider Agreement, the obligations, duties and responsibilities of the parties with respect to that population will be terminated except as specified in Appendix P as of the date funding expires. If the Ohio General Assembly or the United States government fails at any time to provide

sufficient funding for ODM or the State of Ohio to make payments due under this Provider Agreement, this Provider Agreement will terminate as of the date funding expires without further obligation of ODM or the State of Ohio.

#### ARTICLE IX - AMENDMENT AND RENEWAL

- A. This Provider Agreement may be amended only by a writing signed by both parties. Any written amendments to this Provider Agreement shall be prospective in nature.
- B. In the event that changes in state or federal law, regulations, an applicable waiver or state plan amendment, or the terms and conditions of any applicable federal waiver or state plan amendment, require ODM to modify this Agreement, ODM shall notify the MCOP regarding such changes and this Agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this Article of this Agreement.

#### ARTICLE X - LIMITATION OF LIABILITY

- A. The MCOP agrees to indemnify and to hold ODM and the state of Ohio harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of the MCOP in the fulfillment of this Provider Agreement or arising from this Agreement which are attributable to the MCOP's own actions or omissions, or of those of its trustees, officers, employees, agents, subcontractors, suppliers, third parties utilized by the MCOP, or joint ventures'. Such claims shall include but are not limited to: any claims made under the Fair Labor Standards Act or under any other federal or state law involving wages, overtime, or employment matters and any claims involving patents, copyrights, trademarks and applicable public records laws. The MCOP shall bear all costs associated with defending ODM and the state of Ohio against these claims.
- B. The MCOP hereby agrees to be liable for any loss of federal funds suffered by ODM for enrollees resulting from specific, negligent acts or omissions of the MCOP or its subcontractors during the term of this Agreement, including but not limited to the nonperformance of the duties and obligations to which the MCOP has agreed under this Agreement.
- C. In the event that, due to circumstances not reasonably within the control of the MCOP or ODM, a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection occurs, neither ODM nor the MCOP will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided that so long as the MCOP's Certificate of Authority remains in full force and effect, the MCOP shall be liable for the covered services required to be provided or arranged for in accordance with this Agreement.
- D. In no event shall ODM be liable for indirect, consequential, incidental, special or punitive damages, or lost profits.

#### ARTICLE XI - ASSIGNMENT

- A. ODM will not allow the transfer of Medicaid members by one MCOP to another entity without the express prior written approval of ODM. Even with ODM's prior written approval, ODM reserves the right to offer such members the choice of MCOPs outside the normal open enrollment process and implement an assignment process as ODM determines is appropriate. MCOPs shall not assign any interest in this Provider Agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODM and subject to such conditions and provisions as ODM may deem necessary. No such approval by ODM of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement. Any member transfer and/or assignments of interest shall be submitted for ODM's review 120 days prior to the desired effective date. ODM shall use reasonable efforts to respond to any such request for approval within the 120 day period. Failure of ODM to act on a request for approval within the 120 day period does not act as an approval of the request. ODM may require a receiving MCOP to successfully complete a readiness review process before the transfer of members or obligations under this Agreement.
  
- B. The MCOP shall not assign any interest in subcontracts of this Provider Agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODM and subject to such conditions and provisions as ODM may deem necessary. Any such assignments of subcontracts shall be submitted for ODM's review 30 days prior to the desired effective date. No such approval by ODM of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement.

#### ARTICLE XII - CERTIFICATION MADE BY THE MCOP

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

- C. The MCOP certifies that neither the MCOP nor any principals of the MCOP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCOP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal agency. The MCOP also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC Section 153.02 or ORC Section 125.25. The MCOP also certifies that the MCOP has no employment, consulting or any other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the MCOP's contractual obligation with ODM. This certification is a material representation of fact upon which reliance was placed when this Provider Agreement was entered into. Federal financial participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services. If it is ever determined that the MCOP knowingly executed this certification erroneously, then in addition to any other remedies, this Provider Agreement shall be terminated pursuant to Article VIII, and ODM must advise the Secretary of the appropriate federal agency of the knowingly erroneous certification.
- D. The MCOP certifies that the MCOP is not on the most recent list established by the Secretary of State, pursuant to Section 121.23 of the ORC, which identifies the MCOP as having more than one unfair labor practice contempt of court finding. This certification is a material representation of fact upon which reliance was placed when this Provider Agreement was entered into.
- E. The MCOP agrees not to discriminate against individuals who have or are participating in any work program administered by a County Department of Job and Family Services (CDJFS) under Chapters 5101 or 5107 of the ORC.
- F. The MCOP certifies and affirms that, as applicable to the MCOP, that no party listed or described in Division (I) or (J) of Section 3517.13 of the ORC who was in a listed position at the time of the contribution, has made as an individual, within the two previous calendar years, one or more contributions in excess of one thousand and 00/100 (\$1,000.00) to the present governor or to the governor's campaign committees during any time he/she was a candidate for office. This certification is a material representation of fact upon which reliance was placed when this Provider Agreement was entered into. If it is ever determined that the MCOP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, the MCOP shall return to ODM all monies paid to the MCOP under this Provider Agreement. The provisions of this section shall survive the expiration or termination of this Provider Agreement.
- G. The MCOP agrees to refrain from promising or giving to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties.
- H. The MCOP agrees to comply with the false claims recovery requirements of 42 U.S.C

1396a(a)(68) and to also comply with ORC 5162.15.

- I. The MCOP, its officers, employees, members, any subcontractors, and/or any independent contractors (including all field staff) associated with this Agreement agree to comply with all applicable state and federal laws regarding a smoke-free and drug-free workplace. The MCOP will make a good faith effort to ensure that all MCOP officers, employees, members, and subcontractors will not purchase, transfer, use or possess illegal drugs or alcohol, or abuse prescription drugs in any way while performing their duties under this Agreement.
- J. The MCOP certifies and confirms that any performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention.
- K. The MCOP certifies and confirms that it agrees to comply with all applicable standards orders or regulations of the Clean Air Act and Federal Water Pollution Control Act.
- L. The MCOP agrees that it is in compliance with the Federal Acquisition Regulation (FAR) for Combatting Trafficking in Persons, 48 CFR Subpart 22.17, in which “the United States Government has adopted a zero tolerance policy regarding trafficking in persons.” The provisions found in 48 CFR Subpart 52.2, specifically Subpart 52.222-50 are hereby incorporated into this Agreement by reference. ODM reserves the right to immediately and unilaterally terminate this Agreement if any provision in this Section is violated and ODM may implement section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 USC 7104), *see* 2 CFR Part 175.

#### ARTICLE XIII - CONSTRUCTION

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

#### ARTICLE XIV - INCORPORATION BY REFERENCE

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

specifically restated herein. Appendix P and any other applicable obligations set forth in this Provider Agreement will survive the termination or non-renewal of this Agreement.

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

#### ARTICLE XV – NOTICES

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

#### ARTICLE XVI – HEADINGS

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

The parties have executed this Agreement as of the date signed by the ODM Director. The Agreement is hereby accepted and considered binding in accordance with the terms and conditions set forth in the preceding statements.

INSERT MCOP NAME

BY: \_\_\_\_\_  
INSERT TITLE

DATE: \_\_\_\_\_

INSERT ADDRESS

THE OHIO DEPARTMENT OF MEDICAID:

BY: \_\_\_\_\_  
JOHN B. MCCARTHY, MEDICAID DIRECTOR

DATE: \_\_\_\_\_

50 West Town Street, Columbus, Suite 400, Columbus, Ohio 43215

**Ohio Department of Medicaid (ODM)  
MyCare Ohio Provider Agreement  
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## **APPENDIX A**

### **ODM RULES, OAC CHAPTERS 5160-58 AND 5160-26**

The MyCare Ohio managed care program rules can be accessed electronically through the Managed Care page of the Ohio Department of Medicaid website.

**APPENDIX B**

**SERVICE AREA SPECIFICATIONS**

**MY CARE OHIO PLAN:**

**The MyCare Ohio Plan agrees to provide Medicaid services to individuals dually eligible for Medicare and Medicaid pursuant to OAC rule 5160-58-02 residing in the following service area(s):**

**Service Area Regions**

- |                   |                          |
|-------------------|--------------------------|
| Central           | <input type="checkbox"/> |
| East Central      | <input type="checkbox"/> |
| Northeast         | <input type="checkbox"/> |
| Northeast Central | <input type="checkbox"/> |
| Northwest         | <input type="checkbox"/> |
| West Central      | <input type="checkbox"/> |
| Southwest         | <input type="checkbox"/> |

\*The MyCare Ohio Plan must serve all counties in any region they agree to serve. See the next page for a list of counties in each service area region.

OHIO MY CARE OHIO PLAN SERVICE AREA REGIONS BY COUNTY

The MyCare Ohio Program consists of 29 counties grouped into seven service area regions identified below.

Counties in Central: Delaware, Franklin, Madison, Pickaway, and Union counties

Counties in East Central: Portage, Stark, Summit, and Wayne counties

Counties in Northeast: Cuyahoga, Geauga, Lake, Lorain, and Medina counties

Counties in Northeast Central: Columbiana, Mahoning, and Trumbull counties

Counties in Northwest: Fulton, Lucas, Ottawa, and Wood counties

Counties in West Central: Clark, Greene, and Montgomery counties

Counties in Southwest: Butler, Clermont, Clinton, Hamilton, and Warren counties

## APPENDIX C

### MYCARE OHIO PLAN RESPONSIBILITIES

The following are MyCare Ohio Plan (MCOP) responsibilities that are not otherwise specifically stated in OAC rule provisions or elsewhere in the MCOP provider agreement, but are required by the Ohio Department of Medicaid (ODM).

#### General Provisions

1. The MCOP agrees to implement program modifications as soon as reasonably possible or no later than the required effective date, in response to changes in applicable state and federal laws and regulations.
2. The MCOP must submit a current copy of its Certificate of Authority (COA) to ODM within 30 days of issuance by the Ohio Department of Insurance (ODI).
3. The MCOP must designate the following:
  - a. A primary contact person, the Contract Compliance Officer, as specified in Sections 2.2.2.1 and 2.2.3.4.1.3 of the Three-Way Contract between MCOP, CMS and ODM (Three-Way), who will dedicate a majority of his or her time to the MyCare Ohio (Medicaid-Medicare) product line and coordinate overall communication between ODM and the MCOP. ODM may also require the MCOP to designate contact staff for specific program areas. The Contract Compliance Officer will be responsible for ensuring the timeliness, accuracy, completeness and responsiveness of all MCOP submissions to ODM.
  - b. A provider relations representative for each service area included in its ODM provider agreement. This provider relations representative can serve in this capacity for only one service area.
4. Communications - The MCOP must comply with all aspects of Section 2.2 of the Three-Way. In addition, the MCOP must take all necessary and appropriate steps to ensure that all MCOP staff are aware of, and follow, the following communication process:
  - a. All MCOP employees are to direct all day-to-day submissions and communications to their ODM-designated Contract Administrator within the Bureau of Managed Care (BMC) unless otherwise notified by ODM. If the MCOP needs to contact another area of ODM in any other circumstance, the contract administrator within the BMC must also be copied or otherwise included in the communication.
  - b. Entities that contract with ODM should never be contacted by the MCOP unless ODM has specifically instructed the MCOP to contact these entities directly.

- c. Because the MCOP is ultimately responsible for meeting program requirements, ODM will not discuss MCOP issues with the MCOP's subcontractor unless the MCOP is also participating in the discussion. MCOP subcontractors, with the MCOP participating, should only communicate with the specific Contract Administrator assigned to that MCOP.
5. The MCOP must be represented at all meetings and events designated by ODM that require mandatory attendance.
6. The MCOP must have an administrative office located in Ohio.
7. The MCOP must have its MyCare Ohio Medicaid Managed Care program member call center(s) located in the state of Ohio.
8. The MCOP must have the key MyCare Ohio Medicaid Managed Care program staff specified in Section 2.2.3 of the Three-Way based and working in the state of Ohio. Each key staff person identified in Section 2.2.3 of the Three-Way may occupy no more than one of the positions, unless the MCOP receives prior written approval from ODM stating otherwise.
9. Upon request by ODM, the MCOP must submit information on the current status of their company's operations not specifically covered under this Agreement unless otherwise excluded by law.
10. The MCOP must have all new employees trained on applicable program requirements including those in the Three-Way, and represent, warrant and certify to ODM that such training occurs, or has occurred. Plans must conduct staff training sessions on subjects including disability competency, access, cultural sensitivity, person-centered care delivery approaches and independent living philosophies.
11. All employees of the MCOP and the MCOP's delegated/subcontracted entities who have in-person contact with members in their home must comply with criminal record check requirements as specified by ODM.
12. The MCOP must follow requirements related to moral or religious objections in the Three-Way as specified in Section 5.1.12. If an MCOP determines that it does not wish to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, it must immediately notify ODM to coordinate the implementation of this change. The MCOP will be required to notify its members of this change at least 30 days prior to the effective date. The MCOP's member handbook and provider directory, as well as all marketing materials, will need to include information specifying any such services that the MCOP will not provide.

13. For any data and/or documentation that MCOPs are required to maintain, ODM may request that the MCOP provide analysis of this data and/or documentation to ODM in an aggregate format, such format to be solely determined by ODM.
14. The MCOP is responsible for determining medical necessity for services and supplies requested for their members as specified in OAC rule 5160-58-03. Notwithstanding such responsibility, ODM retains the right to make the final determination on medical necessity in specific member situations.
15. In addition to the timely submission of medical records at no cost for the annual external quality review as specified in OAC rules 5160-58-01.1 and 5160-26-07, the MCOP may be required for other purposes to submit medical records at no cost to ODM and/or its designee upon request.
16. In addition to complying with the requirements in OAC rules 5160-58-01.1 and 5160-26-05, the MCOP must notify the BMC:
  - a. Within one working day of becoming aware that a MCOP panel provider that served 100 or more of the MCOP's members failed to notify the MCOP that they are no longer available to serve as a MCOP panel provider;
  - b. At least four months before the effective date of a systemic change in panel. ODM defines a systemic change in panel as an MCOP-initiated termination or change in availability of any single provider or combination of providers that are included in the provider contract termination in question, serving 100 or more of the MCOP's members. For example, an MCOP terminates 10 providers each serving 25 members. This termination must be reported, even though the providers individually do not meet the 100 member requirement. Overall, the group termination impacts 250 members and must be reported. ODM reserves the right to require that the MCOP align an MCOP- initiated systemic change in panel to the annual open enrollment month; or
  - c. Within one working day of becoming aware of a provider-initiated hospital unit closure.

The MCOP must also follow the requirements set forth in 2.6.1.2 of the Three-Way regarding notification of changes to the MCOP's provider network.

17. Upon ODM's request, the MCOP may be required to provide written notice to members of any significant change affecting contractual requirements, member services or access to providers.
18. Additional Benefits: The MCOP may elect to provide services that are in addition to

those covered under the Ohio Medicaid fee-for-service (FFS) program. Before the MCOP notifies potential or current members of the availability of these services, they must first notify ODM and advise ODM that it plans to make such services available. If an MCOP elects to provide additional services, the MCOP must ensure to the satisfaction of ODM that the services are readily available and accessible to members who are eligible to receive them. Additional benefits must be made available to members for at least six (6) calendar months from date approved by ODM. All additional benefits available to Medicaid-only members must also be approved and available for dual benefits members. Additional benefits may not vary by county within a region except out of necessity for transportation arrangements (e.g., bus versus cab). An MCOP approved to serve consumers in more than one region may vary additional benefits between regions

- a. The MCOP is **required** to make transportation available to any member requesting transportation when the member **must** travel 30 miles or more from his or her home to receive a medically-necessary Medicaid-covered service provided by the MCOP pursuant to OAC rule 5160-58-03 and Appendix G of this Provider Agreement. If the MCOP offers transportation to its members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.
- b. The MCOP must give ODM and members 90 days prior notice when decreasing or ceasing any additional benefits. When an MCOP finds that it is impossible to provide 90 days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, ODM must be notified within at least one working day.

19. Provision of Transportation Services

- a. The MCOP must ensure that transportation pick-up is completed not more than fifteen minutes before or fifteen minutes after the pre-scheduled pick-up time, ensuring the member is on time for their appointment, and no more than 30 minutes after a request for pick-up following a scheduled appointment. The vendor must attempt to contact the member if he or she does not respond at pick-up. The vendor must not leave the pick-up location prior to the pre-scheduled pick-up time. The MCOP must identify and accommodate the special transportation assistance needs of its members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements). Member-specific needs must be communicated to the transportation vendor and updated as frequently as is needed to support the member's needs. Where applicable, these needs must be documented in the member's care plan.
- b. The MCOP must submit a plan for the provision of transportation services during winter snow and other weather emergencies, specifying identification, triage, transportation of consumers requiring critical services, notification to consumers of canceled transportation and rescheduling. The MCOP must specify the snow emergency level and any other weather-related criteria that require a change to

scheduled transportation. The MCOP must notify the Contract Administrator immediately when transportation is canceled in accordance with the plan.

20. Comprehensive Disaster/Emergency Response Planning

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

The MCOP must designate both a primary and alternate point of contact who will perform the following functions: being available 24 hours a day, 7 days a week during the time of an emergency; being responsible for monitoring news, alerts and warnings about disaster/emergency events; having decision-making authority on behalf of the MCOP; responding to directives issued by ODM; and cooperating with the local- and state-level Emergency Management Agencies. The MCOP must communicate any changes to the primary and alternate point of contact to the Contract Administrator at least one business day prior to the effective date of the change.

The MCOP must participate in ODM sanctioned workgroups and processes to establish a state-level emergency response plan which will include a provision for Medicaid consumers, and will comply with the resulting procedures. During the time of an emergency or a natural, technological, or man-made disaster, the MCOP must be able to generate a current list of members for whom an individual disaster plan, according to the specifications below, has been developed, including the risk and the individual-level plan, and distribute to local and state emergency management authorities according to the protocol established by ODM.

Individual Disaster/Emergency Response Plan

The MCOP must identify members who are at risk for harm, loss, or injury during any potential natural, technological, or manmade disaster. The MCOP must assure that every member who is technology and/or service dependent, with no known reasonable means to access services, is known and documented as part of the plan's Comprehensive Disaster/Emergency Response Plan. For these members, the MCOP must develop an individual-level plan with the member if appropriate. The member-level plan must: 1) include a provision for the continuation of critical services appropriate for the member's needs in the event of a disaster; 2) identify how and when the plan will be activated; 3) be documented in the member record maintained by the MCOP; and 4) be provided to the member. The MCOP must ensure that staff, including care managers, are prepared to respond to and implement the plans in the event of an emergency or disaster.

21. The MCOP must comply with any applicable federal and state laws that pertain to member rights and ensure that its staff adheres to such laws when furnishing services to

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

22. Upon request, the MCOP will provide members and potential members with a copy of their practice guidelines.
23. Marketing Materials and Member Materials  
Pursuant to OAC rules 5160-58-01.1, 5160-26-08 and 5160-26-08.2, the MCOP is responsible for ensuring that all MCOP marketing and member materials are prior approved by ODM before being used or shared with members or potential members. Member materials must be available in written format, but can be provided to the member in alternative formats (e.g., CD-ROM) if specifically requested by the member, except as specified in OAC rule 5160-58-08.4. Marketing and member materials are defined as follows:
  - a. Marketing materials are those items produced in any medium, by or on behalf of an MCOP, including gifts of nominal value (i.e., items worth no more than \$15.00), which can reasonably be interpreted as intended to market to eligible individuals as defined in OAC 5160-58-01.
  - b. Member materials are those items developed, by or on behalf of an MCOP, to fulfill MCOP program requirements or to communicate to all members or a group of members. Member health education materials that are produced by a source other than the MCOP and which do not include any reference to the MCOP are not considered to be member materials.
  - c. MCOP marketing and member materials must not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODM.
  - d. MCOP marketing materials cannot contain any assertion or statement (whether written or oral) that the MCOP is endorsed by the Centers for Medicare and Medicaid Services (CMS), the Federal or State government or similar entity.
  - e. The MCOP must establish positive working relationships with the County Department of Job and Family Services (CDJFS) offices and must not aggressively solicit from local Directors, MCOP County Coordinators, or other staff. Furthermore, the MCOP is prohibited from offering gifts to CDJFS offices or Medicaid Consumer Hotline (henceforth referred to as the “Hotline”) staff, as these may influence an individual’s decision to select a particular MCOP.
  - f. MCOP marketing representatives and other MCOP staff are prohibited from offering eligible individuals the use of a portable device (laptop computer, cellular phone, etc.) to assist with the completion of an online application to select and/or change MCOPs,

as all enrollment activities must be completed by the Hotline.

- g. Prior to initiating member-requested Medicare marketing contact with a current or pending member for any corporate-family Medicare Advantage (MA) or Medicare Special Needs Plan (SNP) product, an MCOP member services representative or care manager must identify and resolve any confusion or service issues that may have motivated the member's request for a change in enrollment. MCOP member services representatives or care managers must also educate the member about the MCOP's dual benefits membership option. Once the issues are resolved and clarification about MCOP integrated enrollment is made, the member must be invited to rescind the marketing request.
- h. The MyCare Ohio logo must be on all member and marketing materials, excluding nominal gifts.

24. Cultural Competency and Communication Needs

The MCOP is responsible for promoting the delivery of services in a culturally competent manner, as solely determined by ODM, to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds. The MCOP must make oral interpreter services for all languages available free of charge to all members and eligible individuals pursuant to 42 CFR Section 438.10(c)(4).

The MCOP must comply with the requirements specified in Section 2.12 of the Three-Way for member communication standards and must comply with OAC rules 5160-58-01.1, 5160-26-03.1, 5160-26-05, 5160-26-05.1, 5160-26-08 and 5160-26-08.2 for providing assistance to LEP members and eligible individuals. In addition, the MCOP must provide written translations of certain MCOP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

- a. If ODM identifies prevalent common primary languages other than English in the MCOP's service area, the MCOP, as specified by ODM, must translate marketing and member materials into the primary languages of those groups. In addition, the MCOP must make these marketing and member materials available to eligible individuals free of charge.
- b. The MCOP must utilize a centralized database which records the special communication needs of all MCOP members (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment) and the provision of related services (i.e., MCOP materials in alternate format, oral interpretation, oral translation services, written translations of MCOP materials, and sign language services). This database must include all MCOP member primary language information (PLI) as well as all other special communication needs information for MCOP members, as indicated above, when identified by any source including but not limited to ODM, the Hotline, MCOP staff, providers, and members. This centralized database must be readily available to MCOP staff and be used in coordinating

communication and services to members, including the selection of a primary care provider (PCP) who speaks the primary language of an LEP member, when such a provider is available. The MCOP must share specific communication needs information with its providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and

Third Party Administrators (TPAs)], as applicable. The MCOP must submit to ODM, upon request, detailed information regarding the MCOP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the MCOP as well as those services reported to the MCOP which were arranged by the provider).

Additional requirements specific to providing assistance to hearing-impaired, vision-impaired, LRP, and LEP members and eligible individuals are found in OAC rules 5160-58-01.1, 5160-26-03.1, 5160-26-05, 5160-26-05.1, 5160-26-08, and 5101-3-26-08.2.

- c. The MCOP is responsible for ensuring that all member materials use easily understood language and format. The determination of whether materials comply with this requirement is in the sole discretion of ODM.
  - d. The MCOP must participate in ODM's cultural competency initiatives.
  - e. Person-Centered Language in Communications - The MCOP will use person-centered language in all communication with eligible individuals and members consistent with the definition available at: <http://www.disabilityisnatural.com/explore/professionals-organizations>.
  - f. MCOP HIPAA privacy notices must be translated into other languages pursuant to Marketing Guidance for Ohio Medicare-Medicaid Plans and Title VI of the Civil Rights Act. MCOPs must also assess member primary languages and provide materials in other prevalent languages.
25. Issuance of Member Materials  
The MCOP must provide members with a variety of materials, including at a minimum those specified in the OAC rules, this Provider Agreement and the Three-Way. The following provides clarification regarding the issuance of specific member materials.
- a. New Member Materials - Pursuant to OAC rules 5160-58-01.1 and 5160-26-08.2, MCOPs must provide to each member who selects or changes MCOPs, or changes Medicaid-only or dual benefit status, an MCOP identification (ID) card, a new member letter, a member handbook (including a waiver handbook if applicable), and provider panel information, as specified by ODM.
    - i. The MCOP must use the model language specified by ODM and/or CMS

for the new member letter and member handbooks.

- ii. The MCOP must mail ID cards to each member via a method that will ensure receipt no earlier than 15 days prior to the member's effective date of coverage and no later than the day prior to the member's effective date of coverage.
  - a. An MCOP will meet the timeliness requirement for mailing ID cards to members who select or change MCOPs, or change Medicaid-only or dual benefit status within the five days prior to the end of the month, if the ID cards are mailed within:
    - i. Five working days of the MCOP receiving the ODM produced HIPAA 834C that lists the individual as a Medicaid-only member; or
    - ii. Ten working days of the MCOP receiving the ODM-produced HIPAA 834C that lists the individual as a dual benefits member.
  - b. The MCOP ID card must contain pharmacy information, and the toll-free 24-hour behavioral health crisis and care management telephone numbers as prescribed by ODM.
  - c. For Medicaid Only members when a contracted primary care provider (PCP) is not identified on the consumer contact record (CCR) and the member does not select a PCP, the ID card PCP field must read "Refer to Medicare PCP".
- iii. The MCOP must mail the new member letter and member handbook, including the waiver handbook if applicable, separate from the ID card. An MCOP will meet the timeliness requirement for mailing these materials if they are mailed to members within five working days of the MCOP receiving the ODM produced HIPAA 834C, that lists the individual as a new member.
- iv. The MCOP must provide access to provider panel information to members via the MCOP's website and printed provider directories.
  - a. MCOPs may mail ODM prior-approved provider directory notices to all new members in lieu of mailing printed directories. The notices must be mailed with the member materials specified in 25.a.iii of this Appendix and, at a minimum, advise members they may call the MCOP to request printed provider directories and access the information on the MCOP's website.

- b. MCOPs that mail ODM prior-approved provider directory notices to new members in lieu of mailing printed directories must automatically send printed provider directories to members that voluntarily enroll and request printed provider directories, as reflected on the Consumer Contact Record (CCR). Printed directories must be mailed with the new member materials specified in 25.a.iii of this Appendix.
  - c. MCOPs that do not use an ODM prior-approved provider directory notice must mail printed provider directories to all new members with the member materials specified in 25.a.iii of this Appendix except printed provider directories do not need to be mailed to new members that voluntarily enroll and request to not receive printed provider directories as reflected on the CCR.
  - d. When a member requests a printed provider directory as a result of provider directory notices or after initial months of enrollment, the printed provider directory must be sent to the member within seven calendar days of the request.
- v. Waiver Material
- a. Annual material – The MCOP must issue waiver handbooks annually to members enrolled in the MyCare Ohio waiver. The MCOP is responsible for ensuring that each MyCare Ohio Integrated Care (IC) Waiver enrollee receives the Waiver Member Handbook at the time of enrollment, and also at the time of each annual reassessment. The MCOP is responsible for ensuring that the Waiver Care Manager or Waiver Service Coordinator has verbally reviewed the content of the handbook, and the MCOP shall maintain documentation signed by the enrollee of receipt of this information.
  - b. Member Waiver Service Freedom of Choice Form – For a member who has chosen waiver services, the MCOP must have an ODM-developed freedom of choice form signed by the member indicating he or she has chosen waiver services over institutional care. This form must be signed at the time that the member enrolls in the waiver. In addition, it must be signed annually thereafter at the time of reassessment of waiver eligibility, closest to the member’s level of care redetermination.
  - c. Self-Direction Handbook - The MCOP will provide an ODM-approved handbook on self-direction detailing processes, etc. to all members directing their own care.
- vi. The MCOP must use the model language specified by ODM for the new member letter and as applicable, model language for CMS letters

regarding Cancellation of Enrollment and Confirmation of Voluntary Disenrollment Following CMS Daily Transaction Reply Report (DTRR).

## 26. Healthchek Services

- a. Informing Members About Healthchek - In addition to the Healthchek requirements specified in OAC rules 5160-58-03, 5160-58-01.1 and 5160-26-08.2, the MCOP must:
  - i. Inform each member under the age of 21 within 7 calendar days of their effective date of enrollment in the MCOP about the Healthchek program as prescribed by ODM and as specified by 42 C.F.R. Section 441.56. An MCOP may meet this requirement by including information with the new member materials specified in paragraph 25 of this Appendix. In addition, the MCOP may be required to communicate with the member's local County Department of Job and Family Services agency any requests made by the member for County coordinated services and/or supports (e.g. social services).
  - ii. Provide members with accurate information in the member handbook regarding Healthchek, Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. The MCOP's member handbooks must be provided to members within the time frames specified in 25.d of this Appendix, and must include verbatim the model language developed by ODM. The model language at a minimum will include:
    - a. A description of the types of screening and treatment services covered by Healthchek;
    - b. A list of the intervals at which members under age 21 should receive screening examinations, as indicated by the most recent version of the document entitled "Recommendations for Preventive Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics;
    - c. Information that Healthchek services are provided at no additional cost to the member; and
    - d. Information that providers may request prior authorization for coverage of services that have limitations and/or are not covered for members age 21 and older if the services are medically necessary EPSDT services.
  - iii. Provide the above Healthchek information in 26.a.ii on the MCOP's member website specified in 49.b. of this Appendix.

- iv. Deliver Healthchek information as provided, or as approved, by ODM to the MCOP's members at the following intervals:
    - a. January of each calendar year to all members under the age of 21; and
    - b. At the beginning of each school year in the month of July for members under 21.
  - v. Use the mailing templates provided by ODM that will not exceed two 8x11 pages for each mailing with most mailings being one page or less in length. The MCOP must populate the materials with appropriate Healthchek information as required (e. g. type of service, rendering provider, date of service and age of member on the date of service).
- b. Informing Members about Pregnancy Related Services (PRS)
- i. Upon the identification of a member as pregnant, the MCOP must deliver to the member within 14 calendar days a PRS form as designated by ODM. The MCOP may be required to communicate with the member's local County Department of Job and Family Services agency any requests made by the member for County coordinated services and supports (e.g. social services).
- c. Informing Providers about Healthchek - In addition to the Healthchek requirements specified in OAC rules 5160-58-01.1 and 5160-26-05.1, the MCOP must:
- i. Provide Healthchek education to all contracted providers on an annual basis which must include, at a minimum, the following:
    - a. The required components of a Healthchek exam as specified in Ohio Administrative Code Chapter 5160-14;
    - b. A list of the intervals at which individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document "Recommendations for Preventive Pediatric Health Care" published by Bright Futures/American Academy of Pediatrics;
    - c. A statement that Healthchek includes a range of medically necessary screening, diagnosis and treatment services; and
    - d. A list of common billing codes and procedures related to the Healthchek services (e.g., immunizations, well child exams, laboratory tests, and screenings).

- ii. Provide the above information on the MCOP's provider website as specified in 49.c. of this Appendix.
- d. MCOPs must maintain documentation that it informed members and providers of Healthchek and pregnancy related services as specified by ODM.

27. Advance Directives

All MCOPs must comply with the requirements specified in 42 CFR 422.128. At a minimum, the MCOP must:

- a. Maintain written policies and procedures that meet the requirements for advance directives, as set forth in 42 CFR Subpart I of part 489 (42 CFR 489.100—489.104).
- b. Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCOP to ensure that the MCOP:
  - i. Provides written ODM-approved information to all adult members concerning:
    - a. The member's rights under state law to make decisions concerning his or her medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
    - b. The MCOP's policies concerning the implementation of those rights including a clear and precise statement of any limitation regarding the implementation of advance directives as a matter of conscience;
    - c. Any changes in state law regarding advance directives as soon as possible, but no later than 90 days after the proposed effective date of the change; and
    - d. The right to file complaints concerning noncompliance with the advance directive requirements with the Ohio Department of Health.
  - ii. Provides for education of its staff concerning the MCOP's policies and procedures on advance directives;
  - iii. Provides for community education regarding advance directives directly or in concert with other providers or entities;

- iv. Requires that each member's medical record document whether or not the member has executed an advance directive; and
- v. Does not condition the provision of care, or otherwise discriminate against a member, based on whether the member has executed an advance directive.

28. Call Center Standards

The MCOP must follow call center requirements pursuant to Sections 2.9.2, 2.9.3 and 2.9.4 of the Three-Way.

The MCOP must notify ODM of any hours of operation of the member services lines that are outside the required days and time as specified in Section 2.9.2 of the Three-Way. MCOPs are required to ensure access to medical advice [pursuant to OAC rule 5160-26-03.1(A)(6)], behavioral health crisis, and care management support services through toll-free 24 hour, 7 days a week (24/7) call-in systems that are available nationwide. The 24/7 call-in systems listed in this section must be staffed by appropriately qualified medical and behavioral health professionals whose scope of practice and licensure permits them to perform the required functions associated with the services.

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

For the purpose of meeting the staffing requirement for medical advice, appropriately qualified medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs). The MCOP must ensure that an appropriately qualified health professional is the caller's first point of live contact to answer the call, triage the issue, and determine an immediate course of action (e.g., warm transfer to care manager, offer medical advice). Only one auto-prompt can be used to get the caller to the live contact.

For the purposes of meeting the staffing requirement for behavioral health crisis services, appropriately qualified health professionals must have experience with behavioral crisis assessment and intervention. The MCOP must ensure that an appropriately qualified health professional is the caller's first point of live contact to answer the call, triage the issue, and determine an immediate course of action (e.g., provide intervention, warm transfer to local behavioral health crisis services or care manager). Only one auto-prompt can be used to get the caller to the live contact. Staff must have access to emergency response (e.g., 911, police and fire) and crisis intervention services (pursuant to OAC 5122-29-10 and 3793:2-1-08) in each county in which the plan maintains membership. The MCOP must have arrangements with the county mental health and drug/alcohol crisis lines to assure access to crisis intervention services, and to ensure that contacts with

the publicly available or county's crisis line are reported within one business day to the MCOP. The MCOP must document a member's contact with the plan-administered and county-administered behavioral health crisis line in the care management record and ensure follow up by a care manager as soon as warranted but not later than 24 hours from the time the MCOP becomes aware of a member's behavioral health crisis.

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

The MCOP must meet the current American Accreditation HealthCare Commission/URAC-designed Health Call Center Standards (HCC) for call center abandonment rate, blockage rate and average speed of answer for the medical advice, care management support, and the behavioral health crisis 24/7 toll-free call-in systems. If access to these call-in systems is facilitated through the member services line with auto-prompts to transfer the caller, the MCOP must have a process to measure the above call center standards from the time of selecting the auto prompt. If the MCOP uses the member services line to answer the care management support services contacts (i.e., no auto prompt to transfer), then call center standards for the member services line specified in Section 2.9.2.2 of the Three-Way apply. ODM will inform the MCOPs of any changes/updates to these URAC call center standards.

The member services call center requirement may not be met through the execution of a Medicaid Delegation Subcontract Addendum or Medicaid Combined Services Subcontract Addendum, without prior approval by ODM. With the exception of transportation vendors, the MCOP is prohibited from publishing a delegated entity's general call center number.

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

29. Notification of Voluntary MCOP Membership

To comply with the terms of the ODM State Plan Amendment for the managed care program, the MCOP must inform new members that MCOP membership is voluntary and not required to receive their Medicaid healthcare benefits for the following populations and what steps they need to take if they do not wish to be a member of an MCOP.

- Indians who are members of federally-recognized tribes.
- Until January 1, 2017, children under 19 years of age who are:
  - o In foster care or other out-of-home placement;
  - o Receiving foster care or adoption assistance;
  - o Receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMh) or any other family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

30. Privacy Compliance Requirements

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

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

The MCOP acknowledges that ODM is a Covered Entity under HIPAA. A Covered Entity means a health plan, a health care clearinghouse, or health care provider under 45 CFR 160.103. The MCOP further acknowledges that it is a Business Associate of ODM. A Business Associate means a person or entity that, on behalf of the Covered Entity, maintains, performs, or assists in the performance of a function or activity that involves the use or disclosure of "Protected Health Information" under 45 CFR 160.103. The MCOP, as a Business Associate agrees to comply with all of the following provisions:

- a. **Permitted Uses and Disclosures.** The MCOP will not use or disclose PHI except as provided in this Agreement or as otherwise required under HIPAA regulations or other applicable law.
- b. **Safeguards.** The MCOP will implement sufficient safeguards, and comply with Subpart C of 45 CFR Part 164 pertaining to electronic PHI to prevent the use or disclosure of PHI other than as provided for under this Agreement. Safeguards will be implemented for all paper and electronic PHI created, received, maintained, or transmitted on behalf of ODM.
- c. **Reporting of Disclosures.** The MCOP agrees to promptly report to ODM any inappropriate use or disclosure of PHI that is not in accordance with this Agreement

- or applicable law, including a breach of unsecured PHI as required at 45 CFR 164.410 and any security incident the MCOP has knowledge of or reasonably should have knowledge of under the circumstances.
- d. **Mitigation Procedures.** The MCOP agrees to coordinate with ODM to determine specific actions that will be required of the Business Associates for mitigation, to the extent practical, of the breach. These actions will include notification to the appropriate individuals, entities, or other authorities. Notification or communication to any media outlet must be approved, in writing, by ODM prior to any such communication being released. The MCOP must report all of its mitigation activity to ODM and must preserve all relevant records and evidence.
  - e. **Incidental Costs.** The MCOP shall bear the sole expense of all costs to mitigate any harmful effect, of any breaches or security incidents which were caused by the MCOP, or its subcontractors, in violation of the terms of this Agreement. These costs will include, but are not limited to, the cost of investigation, remediation and assistance to the affected individuals, entities or other authorities.
  - f. **Agents and Subcontractors.** The MCOP, in compliance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2) as applicable, must ensure that all its agents and subcontractors that create, receive, maintain, or transmit PHI from or on behalf of MCOP and/or ODM agree to have, in a written agreement, the same restrictions, conditions, and requirements that apply to MCOP with respect to the use or disclosure of PHI.
  - g. **Accessibility of Information.** The MCOP must make available to ODM such information as ODM may require to fulfill its obligations to provide access to, provide a copy of any information or documents with respect to PHI pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 CFR 164.524 and 164.528 and any amendments thereto.
  - h. **Amendment of Information.** The MCOP shall make any amendment(s) to PHI as directed by, or agreed to, by ODM pursuant to 45 CFR 164.526, or take other steps as necessary to satisfy ODM's obligations under 45 CFR 164.526. In the event that the MCOP receives a request for amendment directly from an individual, agent, or subcontractor, the MCOP must notify ODM prior to making any such amendment(s). The MCOP's authority to amend information is explicitly limited to information created by the MCOP.
  - i. **Accounting for Disclosure.** The MCOP shall maintain and make available to ODM or individuals requesting the information as appropriate, records of all disclosures of PHI in a Designated Record Set as necessary to satisfy ODM's obligations under 45 CFR 164.528. For every disclosure, the record must include, at a minimum, the name of the individual who is the subject of the disclosure, the date of the disclosure,

reason for the disclosure if any, and the name and address of the recipient to which the PHI was disclosed.

- j. **Obligations of ODM.** When the MCOP is required to carry out an obligation of ODM under Subpart E of 45 CFR Part 164, the MCOP agrees to comply with all applicable requirements of Subpart E that would apply to ODM in the performance of such obligation.
  - k. **Access to Books and Records.** The MCOP shall make available to ODM and to the Secretary of the U.S. Department of Health and Human Services any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from ODM, or created or received on behalf of ODM. Such access is for the purposes of determining compliance with the HIPAA Rules.
  - l. **Material Breach.** In the event of material breach of the MCOP's obligations under this Article, ODM may immediately terminate this Agreement as set forth in ARTICLE VI, Section B. Termination of this Agreement will not affect any provision of this Agreement, which, by its wording or its nature, is intended to remain effective and to continue to operate after termination.
  - m. **Return or Destruction of Information.** Upon termination of this Agreement and at the request of ODM, the MCOP will return to ODM or destroy all PHI in MCOP's possession stemming from this Agreement as soon as possible but no later than 90 days, and will not keep copies of the PHI except as may be requested by ODM or required by law, or as otherwise allowed for under this Agreement. If the MCOP, its agent(s), or subcontractor(s) destroy any PHI, then the MCOP will provide to ODM documentation evidencing such destruction. Any PHI retained by the MCOP will continue to be extended the same protections set forth in this Section, HIPAA regulations and this Agreement for as long as it is maintained.
  - n. **Survival.** These provisions shall survive the termination of this Agreement.
31. Electronic Communications  
The MCOP is required to purchase/utilize Transport Layer Security (TLS) for all e-mail communication between ODM and the MCOP. The MCOP's e-mail gateway must be able to support the sending and receiving of e-mail using TLS and the MCOP's gateway must be able to enforce the sending and receiving of email via TLS.
32. UMCOP Membership Acceptance, Documentation and Reconciliation
- a. Medicaid Consumer Hotline Contractor - The MCOP shall provide to the Hotline ODM prior-approved MCOP materials and directories for distribution to eligible individuals who request additional information about the MCOP.
  - b. Enrollment and Capitation Reconciliation

- i. The MCOP shall maintain the integrity of its membership data through reconciliation of the daily HIPAA 834C (Daily Benefit Enrollment and Maintenance File) and the monthly HIPAA 834F (Monthly Benefit Enrollment and Maintenance File) transactions pursuant to ODM instructions. Discrepancies between the HIPAA 834C and 834F that have a negative impact on a member's access to care must be reported to ODM pursuant to ODM instructions.
  - ii. The HIPAA 820 (Monthly Remittance Advice) will contain the following: a capitation payment for each member listed on the HIPAA 834F, a capitation payment/recoupment for changes listed in the daily HIPAA 834C, and any other capitation payment/recoupment. Reconciliation for any discrepancies between the HIPAA 834 and HIPAA 820 is due and must be submitted, as instructed by ODM, no later than 60 days after the issuance of the HIPAA 834F. In the event of changes in the processing dates, the due date will be adjusted accordingly.
  - iii. 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.
- c. Change in Enrollment During Hospital/Inpatient Facility Stay - When an MCOP learns of a currently hospitalized member's intent to disenroll through the CCR or the HIPAA 834, the disenrolling MCOP must notify the hospital/inpatient facility and treating providers as well as the enrolling MCOP, if applicable, of the change in enrollment. The disenrolling MCOP must notify the inpatient facility that it will remain responsible for the inpatient facility charges through the date of discharge; and must notify the treating providers that it will remain responsible for provider charges through the date of disenrollment. The disenrolling MCOP shall not request and/or require that a disenrolled member be discharged from the inpatient facility for transfer to another inpatient facility. Should a discharge and transfer to another inpatient facility be medically necessary, the disenrolling MCOP must notify the treating providers to work with the enrolling MCOP or ODM as applicable to facilitate the discharge, transfer and authorization of services as needed.

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

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

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

- d. Just Cause Requests - As specified by ODM, the MCOP must assist in resolving member-initiated requests affecting membership.
- e. Newborn Notifications – In order to encourage the timely addition and authorization for Medicaid and enrollment in the MCOP, the MCOP must provide notification of the birth to the CDJFS.

The MCOP must notify the CDJFS and provide at a minimum the mother's name, social security number, eligibility system case number, 12 digit recipient ID, county and the newborn's name, gender, and date of birth, unless the CDJFS and the MCOP have agreed to a different minimum set of information to be transmitted for the CDJFS newborn notification. The MCOP must send this information within five working days of the birth, or immediately upon learning of the birth.

- f. Eligible Individuals (as defined by OAC 5160-58-01) - If an eligible individual contacts the MCOP, the MCOP must provide any MCOP-specific managed care program information requested. The MCOP must not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/transitioning health care services, the MCOP shall provide an assurance that all MCOPs must cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.
- g. Pending Member - If a pending member (i.e., an eligible individual subsequent to MCOP selection or assignment to an MCOP, but prior to his or her membership effective date) contacts the selected MCOP, the MCOP must provide any membership information requested, including but not limited to explaining how to access services as an MCOP member and assistance in determining whether current services require prior authorization. The MCOP must also ensure that any care coordination (e.g., PCP selection, prescheduled services and transition of services) information provided by the pending member is logged in the MCOP's system and forwarded to the appropriate MCOP staff for processing as required.

- The MCOP may confirm any information provided on the CCR at this time. Such communication does not constitute confirmation of membership. Upon receipt of the CCR or the HIPAA 834, the MCOP may contact a pending member to confirm information provided on the CCR or the HIPAA 834, assist with care coordination and transition of care, and inquire if the pending member has any membership questions.
33. The MCOP must use ODM-provided historic utilization and prior authorization data files for care coordination/management activities and transition of care requirements.
34. Retroactive Coverage Requirements and Transition of Fee-For-Service (FFS) Members  
The MCOP must pay claims for covered services provided to members during retroactive enrollment periods. For services provided during retroactive enrollment periods, MCOPs may review only those services that require FFS prior authorization as documented in Appendix DD of OAC 5160-1-60, OAC 5160-9-12 (regarding pharmacy claims), and all other FFS regulations that set forth prior authorization policy. If the service was reviewed and approved by FFS, the MCOP must also approve the service. MCOPs may also review to determine that home and community-based services were in accordance with the pre-existing or current waiver services plan of care.
- a. Upon a member's initial enrollment in MyCare Ohio, the MCOP must provide transition of Medicare and Medicaid services in accordance with the requirements specified in Section 2.5.4 of the Three-Way for both contracted and non-contracted providers. Non-contracted providers who provide services during the transition of Medicare and Medicaid services specified in Section 2.5.4 of the Three-Way must be paid the Medicaid fee for service (FFS) rate. Prior to the end of any required transition period, the MCOP must inform the member and non-contracted provider of the effective date of any transition to a contracted provider, during a meeting of the trans-disciplinary care team or by another method documented in the care plan.
  - b. Unless the provider has expressly agreed to MyCare Ohio contract terms that include quality incentives and a different secondary claims payment rate, not including simple rate changes proposed by the MCOP, the MCOP must pay Medicare secondary claims at a rate not less than that established by the Medicaid fee for service Part B methodology, set forth in O.A.C. 5160-1-05.3, for contracted and non-contracted providers. Exemptions to the Part B Medicaid maximum policy must be applied, in accordance with the Ohio Administrative Code and other guidance issued by ODM. The Part C Medicaid maximum policy, set forth in O.A.C. 5160-1-05.1, may only be applied for secondary claims on behalf of Medicaid only members enrolled with a Part C plan that is not the MCOP. The MCOP must provide a method for enrollment of any non-contracted provider who is an enrolled provider with ODM for purposes of Medicaid payment of "crossover" claims pursuant to the CMCS-MMCO-CM Informational Bulletin of June 7, 2013.
  - c. The MCOP must contract directly with the Fiscal Management Service (FMS) vendor also under contract with ODM to successfully transition and provide ongoing services

- for waiver consumers who have elected self-directed employer authority for authorized waiver services. The contract must continue for the entire period of this Provider Agreement.
- d. Upon receipt, the MCOP must be able to process and use the FFS historic utilization, prior authorization and care management data files to assess pending members' risk stratification levels, to coordinate care and to adhere to transition requirements. When waiver service coordination data is omitted from the file transfer for a pending member enrolled in the FFS Passport, or Assisted Living waiver, the MCOP must reconcile the enrollment or data error with the Passport Administrative Agency (PAA). When waiver service coordination data is omitted for pending members in the Ohio Home Care waiver, the MCOP must notify its Contract Administrator to request enrollment reconciliation and/or data completion.
  - e. The MCOP must make express arrangements to obtain current treatment plans from Ohio Department of Mental Health and Addiction Services (MHAS) certified providers when a member's behavioral health services qualify for transition pursuant to Section 2.5.4 of the Three-Way.
  - f. Member Transition of Care for Prescription Drugs - The MCOP is responsible for implementing transition of care processes that prevent access problems for members that are transitioning from the FFS pharmacy benefit administrator to an MCOP. The transition of care processes for prescription drugs must be consistent the requirements outlined in Medicare Part D.
35. Transition of Care Requirements for Members of an Exiting MCOP  
When the enrolling MCOP is informed by ODM, or its designee, of a member transitioning from the exiting MCOP, the enrolling MCOP must follow the transition of care requirements required by ODM.
36. Transition of Care Requirements for Members receiving HCBS Waiver Services who lose MyCare Ohio Eligibility  
After a MCOP has been notified by ODM via the 834C or 834F, CCR, or other mechanism, and/or another source of information (e.g., waiver service coordinator, member, provider), whichever is the earliest provided to the MCOP, that a member who is receiving HCBS waiver services and whose enrollment is or may be terminating due to loss of MyCare Ohio eligibility, the MCOP must identify the reason for loss of eligibility and timely assist the member, as appropriate, with maintenance of MyCare Ohio eligibility. Upon confirmation that MyCare Ohio eligibility will be terminated, during the last month of the individual's active membership, the MCOP must instruct the appropriate local Area Agency on Aging to end the MyCare Ohio waiver span in alignment with enrollment termination, and facilitate, as appropriate, referrals to programs (e.g., Medicaid waivers) and/or community resources that may assist the individual with continuation of long term services and supports. The MCOP must notify the member and all current waiver providers of the member's termination from MyCare Ohio, and as applicable, of any referral made to other Medicaid waivers. These referrals

and notifications must be completed prior to the end of the month of termination, and when this is not possible, as soon as possible thereafter. If the member is found eligible for return to a Medicaid waiver program, the MCOP must provide the MyCare Ohio waiver service plan and any identified service issues or follow-up necessary to successfully transfer care to the waiver care management agency.

37. Transition of Care Requirements for Members receiving HCBS Waiver Services who move outside of the MCOP's service area.

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

38. Transition of Care Requirements for Members who are changing MyCare Ohio Plans

When the MCOP is informed by ODM, or its designee, of a member who is changing to a different MCOP, the disenrolling MCOP must share, at a minimum, the current assessment and care plan, inclusive of the waiver service plan, with the enrolling MCOP prior to the new enrollment effective date.

39. Assisting Members in Maintaining Medicaid Eligibility

Beginning January 1, 2015, the MCOP must assist members with maintenance of Medicaid eligibility by providing timely reminders of annual redetermination dates.

40. The MCOP must ensure accurate claims payment to nursing facility (NF) and home and community-based services (HCBS) waiver providers by appropriately modifying payment when a member has patient liability obligations, lump sum amount(s) pursuant to 5160-3-39.1, and/or restricted Medicaid coverage periods (RMCP). The MCOP is prohibited from paying for NF services and LTSS during a (RMCP). The MCOP must accept provider documentation of determinations made by County Department of Job and Family Services (CDJFS) for patient liability obligations, lump sum amounts, and RMCPs.

41. Patient liability and cost of care reconciliation: Pursuant to Appendix B-5.c.i of the approved 1915(c) MyCare Ohio waiver, following a 4-month claims run-out period, MCOPs must provide monthly reconciliation reports, as designated by ODM, to each AAA documenting any month for which the waiver member's actual cost of LTSS waiver services is less than the member's patient liability amount for the same period. For all members except those using the Assisted Living Service, the report must specify the actual payment amount of LTSS waiver services delivered and the patient liability amount for the applicable month. The report must be submitted to the AAA no

later than the 15<sup>th</sup> of the month. If no members meet the reporting criteria, the MCOP must enter 'N/A' in the first row of all columns and submit as instructed.

42. Waiver Enrollment

For new enrollment on the MyCare waiver, the MCOP or its designee must assist the member in contacting the local waiver agency for assessment and coordinating waiver eligibility requests through the CDJFS. The CDJFS will generate a waiver eligibility approval or denial notice with hearing rights. MCOPs must authorize waiver services in accordance with OAC 5160-58-01.1 and 5160-26-03.1.

43. Health Information System Requirements

The ability to develop and maintain information management systems capacity is crucial to successful plan performance. ODM therefore requires MCOPs to demonstrate their ongoing capacity in this area by meeting several related specifications.

a. Health Information System

- i. As required by 42 CFR 438.242(a), the MCOP must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and MCOP membership terminations for other than loss of Medicaid eligibility.
- ii. As required by 42 CFR 438.242(b)(1), the MCOP must collect data on member and provider characteristics and on services furnished to its members.
- iii. As required by 42 CFR 438.242(b)(2), the MCOP must ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic, and consistency, and collecting service information in standardized formats to the extent feasible and appropriate.
- iv. As required by 42 CFR 438.242(b)(3), the MCOP must make all collected data available upon request by ODM or CMS.
- v. Acceptance testing of any data that is electronically submitted to ODM is required:
  - a. Before the MCOP may submit production files;
  - b. Whenever the MCOP changes the method or preparer of the electronic media; and/or

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

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

Submission of test files can start before the new or modified information system is in production. ODM reserves the right to verify any MCOP's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period. Sanctions for noncompliance with this requirement are specified in the Compliance Methodology document.

- b. Electronic Data Interchange, Claims Adjudication and Payment Processing Requirements

- i. Claims Adjudication

The MCOP must have the capacity to electronically accept and adjudicate all claims to final status (payment or denial). Information on claims submission procedures must be provided to non-contracting providers within thirty days of a request. The MCOP must inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information must be initiated by the MCOP and not only in response to provider requests.

The MCOP must notify providers who have submitted claims of claims status [paid, denied, pended (suspended)] within one month of receipt by the MCOP or its designee. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly, or more frequent, basis.

The MCOP must implement an Electronic Visit Verification (EVV) system on a timeframe determined by ODM. The timeframe will be no earlier than the timeframe when Fee-For-Service Medicaid implements the EVV system (currently anticipated for January 2017 or July 2017). The MCOP may use the data collection system established by ODM, or may

elect to implement another EVV data collection system so long as it meets all of the ODM data collection system requirements. The MCOP EVV data collection system must successfully provide data to the ODM data gathering system. The MCOP shall utilize data from the EVV data collection system to adjudicate service claims for private duty nursing, state plan home health nursing and aide services, RN assessment services, and waiver nursing and aide services. Prior to implementation, the MCOP must inform providers of the use of the EVV data collection system and how the data will be utilized by the MCOP. The MCOP must also provide assistance on utilization of the collection system, as appropriate, to individuals receiving services, direct care workers and providers.

- ii. The MCOP is prohibited from recovering back or adjusting any payments that are beyond two years from the date of payment of the claim due to the MCOP member's retroactive termination of coverage from the MCOP, unless the MCOP is directed to do so by CMS, ODM, or applicable state or federal law and regulation. However, the preceding sentence does not prohibit the MCOP or ODM from initiating a recovery or adjustment more than two years after the payment of a claim in the event of fraud, abuse, or as otherwise provided by applicable state or federal law and regulation.
- iii. The MCOP must have policies providing that, upon discovery of claims payment systemic errors that resulted in incorrectly underpaying or denying claims, the MCOP is required to reprocess and correctly pay such claims, from the date of identification of the error retroactively through the period specified in the contract between the MCOP and the provider for claims payment corrective activity. A claims payment systemic error is defined as involving more than five providers, or involving a significant number of payment errors if five or fewer providers are affected. If a claims payment systemic error occurs, the MCOP shall notify ODM of the error and shall specify its process and timeline for corrective action, unless the MCOP corrects the payments within 60 days from the date of identification of the error. The MCOP's policies must include how corrective action will be taken on behalf of all affected providers, regardless of whether the claims payment systemic error is identified by the MCOP or by any provider. If the error is not a claims payment systemic error, the MCOP shall correct the payments within 60 days from the date of identification of the error.
- iv. The MCOP is prohibited from engaging in practices that unfairly or unnecessarily delay the processing or payment of any claim for MCOP members.
- v. Electronic Data Interchange

The MCOP shall comply with all applicable provisions of HIPAA including electronic data interchange (EDI) standards for code sets and the following electronic transactions:

Health care claims;  
Health care claim status request and response;  
Health care payment and remittance status;  
Standard code sets; and  
National Provider Identifier (NPI).

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

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

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

ASC X12 834 - Benefit Enrollment and Maintenance.

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

- vi. Documentation of Compliance with Mandated EDI Standards. The capacity of the MCOP and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions in compliance with standards and effective dates mandated by HIPAA must be demonstrated, to the satisfaction of ODM, as outlined below.
- vii. Verification of Compliance with HIPAA. The MCOP shall comply with the transaction standards and code sets for sending and receiving applicable transactions as specified in 45 CFR Part 162 (HIPAA regulations). In addition the MCOP must enter into the appropriate trading partner agreement and implemented standard code sets. If the MCOP has obtained third-party certification of HIPAA compliance for any of the items listed below, that certification may be submitted in lieu of the MCOP's written verification for the applicable item(s).
  - i. Trading Partner Agreements

- ii. Code Sets
- iii. Transactions
  - a. Health Care Claims or Equivalent Encounter Information (ASC X12N 837 & NCPDP 5)
  - b. Eligibility for a Health Plan (ASC X12N 270/271)
  - c. Referral Certification and Authorization (ASC X12N 278)
  - d. Health Care Claim Status (ASC X12N 276/277)
  - e. Enrollment and Disenrollment in a Health Plan (ASC X12N 834)
  - f. Health Care Payment and Remittance Advice (ASC X12N 835)
  - g. Health Plan Premium Payments (ASC X12N 820)
  - h. Coordination of Benefits
- viii. Trading Partner Agreement with ODM

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

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

c. Encounter Data Submission Requirements

General Requirements

Each MCOP must collect data on services furnished to members through a claims system and must report encounter data to the ODM. The MCOP is required to submit this data electronically to ODM as specified in Appendix L.

Acceptance Testing

The MCOP must have the capability to report all elements in the Minimum Data Set as set forth in the ODM Encounter Data Specifications and must submit a test file in the ODM-specified medium in the required formats prior to contracting or prior to an information systems replacement or update.

Acceptance testing of encounter data is required as specified in Section 37.a.v. of this Appendix.

Encounter Data File Submission Procedures

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 MCOP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCOP's CEO or CFO.

- d. The MCOP must submit files as specified in the *MyCare Ohio Nursing Facility Specifications and Submission Instructions* within timeframes specified by ODM. In addition, the MCOP must also collect and submit to ODM upon request the actual nursing facility admission date (any payer) of each member for whom a 100-day threshold was submitted.

- e. IDSS Data Submission and Audit Report Requirements

In accordance with 42 CFR 438.606, the MCOP must submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODM. Each MCOP must also submit to ODM a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODM.

Each data certification letter is due to ODM on the same day the respective HEDIS IDSS data/FAR is to be submitted. For complete instructions on submitting the data certification letters, see *ODM Methodology for MCOP Self-Reported, Audited HEDIS Results*.

- f. Information Systems Review

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

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

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

- iii. Conduct interviews with MCOP staff responsible for completing the ISCA, as well as staff responsible for aspects of the MCOP's information systems function;
  - iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with MCOP staff, and write a statement of findings about the MCOP's information system;
  - v. Assess the ability of the MCOP to link data from multiple sources;
  - vi. Examine MCOP processes for data transfers;
  - vii. If an MCOP has a data warehouse, evaluate its structure and reporting capabilities;
  - viii. Review MCOP processes, documentation, and data files to ensure that they comply with state specifications for encounter data submissions; and
  - ix. Assess the claims adjudication process and capabilities of the MCOP.
44. If the MCOP will be using the Internet functions that will allow approved users to access member information (e.g., eligibility verification), the MCOP must ensure that the proper safeguards, firewalls, etc., are in place to protect member data.
45. The MCOP must receive prior written approval from ODM before adding any information to its website that would require ODM prior approval in hard copy form (e.g., provider listings, member handbook information).
46. Pursuant to 42 CFR 438.106(b), the MCOP acknowledges that it is prohibited from holding a member liable for the cost of services provided to the member in the event that the ODM fails to make payment to the MCOP.
47. In the event of an insolvency of an MCOP, the MCOP, as directed by ODM, must cover the continued provision of services to members until the end of the month in which insolvency has occurred, and must also continue the coverage of inpatient services until the date of discharge for a member who is institutionalized when insolvency occurs.
48. Information Required for MCOP Websites
- a. On-line Provider Directory – The MCOP must have an internet-based provider directory in the same format as its ODM-approved provider directory, that allows members to electronically search for the MCOP panel providers based on name,

provider type and geographic proximity (as specified in Appendix H and the Three-Way Contract). MCOP provider directories must include all MCOP-contracted providers (except as specified by ODM) as well as all federally qualified health centers, rural health centers, qualified family planning providers, and free-standing birth centers (FBCs) as defined in OAC 5160-18-01 located in the MCOP's service regions. If an MCOP does not have contracted certified nurse midwives [CNMs] or certified nurse practitioners [CNPs] in a service region, then the MCOP must specify that CNM and CNP services are available and that members can contact the MCOP for information on accessing those services. The provider directory must be the same for both Medicaid-only and dual eligible members.

- b. On-line Member Website – The MCOP must have a secure internet-based website which provides members the ability to submit questions, comments, grievances, and appeals, and receive a response. Members must be given the option of a response by return e-mail or phone call. The MCOP's responses to questions or comments must be made within one working day of receipt. The MCOP's responses to grievances and appeals must adhere to the timeframes specified in OAC rule 5160-58-08.4. The member website must be regularly updated to include the most current ODM-approved materials, although this website must not be the only means for notifying members of new and/or revised MCOP information (e.g., change in holiday closures, changes in additional benefits, and revisions to approved member materials). The MCOP must make a copy of its Authorized Representative request form available to members through its online member portal located on the MCOP's website.

The MCOP member website must also include, at a minimum, the following information which must be accessible to members and the general public without any log-in restriction: (1) MCOP contact information, including the MCOP's toll-free member services phone number, service hours, and closure dates; (2) a listing of the counties the MCOP serves unless the MCOP serves the entire state in which case the MCOP may indicate it services the entire states; (3) the ODM-approved MCOP member handbook, recent newsletters and announcements; (4) the MCOP's on-line provider directory as referenced in section 49.a. of this Appendix; (5) a list of services requiring prior authorization (PA); (6) the MCOP's preferred drug list (PDL), including an explanation of the list and identification of any preferred drugs that require PA, the MCOP's list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCOP's policy for coverage of generic versus brand name drugs ; (7) the toll-free telephone numbers for the 24/7 medical advice, behavioral health crisis and care management support services call-in systems specified in section 28 of this Appendix; and (8) contact information to schedule non- emergency transportation assistance, including an explanation of the available services and to contact member services for transportation services complaints. The toll-free member services, 24/7 call-in systems and transportation scheduling telephone numbers must be easily identified on either the MCOP's website home page or a page that is direct link from a contact button on the home page. ODM may require the MCOP to include additional information on the member website as needed.

Provide all Healthchek information as specified in 26.a.i. of this Appendix.

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

The MCOP provider website must also include, at a minimum, the following information which must be accessible to providers and the general public without any log-in restrictions: (1) MCOP contact information, including the MCOP’s designated contact for provider issues; (2) a listing of the counties the MCOP serves unless the MCOP serves the entire state in which case the MCOP may indicate it services the entire states; (3) the MCOP’s provider manual including the MCOP’s claims submission process, as well as a list of services requiring PA, recent newsletters and announcements; (4) the MCOP’s policies and procedures for out-of-network providers to seek payment of claims for emergency, post-stabilization and any other services authorized by the MCOP; (5) the MCOP’s on-line provider directory as referenced in section 49.a. of this appendix; and (6) the MCOP’s PDL, including an explanation of the list and identification of any preferred drugs that require PA, the MCOP’s list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCOP’s policy for coverage of generic versus brand name drugs. ODM may require the MCOP to include additional information on the provider website as needed.

The MCOP must provide prescribers with in-office access to their preferred drug and PA lists via the availability of at least one hand-held software application.

The MCOP must provide all Healthchek information as specified in 26.c.i. of this Appendix.

- d. The MCOP must adhere to website requirements set forth in 2.12.5.1.4 and 2.14.3.1.3 of the Three-Way Contract.
49. The MCOP must provide members with a printed version of its Preferred Drug List (PDL) and Prior Authorization (PA) lists upon request.
50. PCP Feedback – The MCOP must have the administrative capacity to offer feedback to individual providers on their: 1) adherence to evidence-based practice guidelines; and 2) positive and negative care variances from standard clinical pathways that may impact outcomes or costs. In addition, the feedback information may be used by the MCOP for

activities such as provider performance improvement projects that include incentive programs or the development of quality improvement programs.

51. COBA (Coordination of Benefits Agreement)

The MCOP must maintain and update their COBA Attachment to the ODM COBA Agreement with CMS' Benefits Coordination and Recovery Center (BCRC). The MCOP must provide ODM with a COBA communication contact to coordinate communication and attend meetings with the BCRC and ODM. The MCOP must also provide ODM with a technical contact to answer questions about the file transfer process and attend technical meetings as required to successfully test and administer the COBA process. Technical and Communication contacts are required to attend a monthly conference call for **Group 2** titled: *Medicaid/Fiscal Agents*, hosted by the BCRC.

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

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

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

52. Third Party Liability (TPL)

- a. Coordination of Benefits - When a claim is denied due to TPL, the MCOP must timely share appropriate and available information regarding the third party to the provider for the purposes of coordination of benefits, including, but not limited to TPL information received from ODM. In addition, the MCOP must follow the requirements set forth in 5.1.13 of the Three-Way Contract.
- b. Recovery – ODM reserves the right to collect and retain any recovery of third party resources for individuals assigned to the MCOPs for collection to the extent that the third party resources remain uncollected from one year from the payment date of the claim.

53. MCOP Submission Due Dates

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

54. The MCOP must subscribe to the appropriate distribution lists for notification of all OAC rule clearances, final rules published with medical assistance letters (MALs), Medicaid handbook transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. The MCOP is solely responsible for submitting its names and email addresses to the appropriate distribution lists and is also responsible for ensuring the validity of any e-mail addresses maintained on those distribution lists.
55. Transfer of PHI from ODM Incident Management and Provider Oversight Contractor(s)  
ODM contracts with a vendor, Public Consulting Group (PCG), to serve as the incident management vendor for ODM with respect to the management and investigation of incidents and provider oversight for certain Ohio Medicaid waiver and Specialized Recovery Services (SRS) program consumers. The MCOP shall report and investigate incidents for MyCare Ohio waiver and SRS program members in accordance with OAC rule 5160-58-05.3

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

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

Data shall be transferred in electronic format. It shall include the data fields set forth in the data transfer document that was jointly developed by ODM, PCG, and the MCOPs. MCOPs must also provide waiver member case notes (at least one month prior to the incident), the most recent assessment, and the service plan in effect at the time of the incident. Plans are encouraged to submit these documents at the time the incident report is made to PCG, but when that is not possible, MCOPs must send them to PCG no later than three working days after submitting the incident report to PCG. For the purpose of investigating incidents set forth in OAC rule 5160-58-05.3 (F)(1) through (F)(5), PCG, ODM or PCG and ODM jointly may ask for additional information, records, data, documentation, prevention plans, etc. as deemed necessary by ODM or PCG to complete the investigation or prevention plan evaluation. If necessary to ensure the immediate health and welfare of the members, the request may be made before the three working days standard. The MCOP shall respond promptly to PCG and/or ODM requests for documentation (so as to ensure that incident investigations may be completed within the required timeframe established in OAC rule 5160-58-05.3 or as otherwise instructed by ODM). MCOPs and PCG shall exchange such information as necessary for the MCOP to meet both entities’ contractual duties under this Agreement. The MCOP shall be held to the requirements set forth in the ODM MyCare Ohio Waiver Incident Escalation Procedure. If ODM learns that an MCOP has not promptly submitted required materials, ODM may impose a sanction on the MCOP in accordance with Appendix N.

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

The MCOP must also establish SFTP and VPN secure data transfer methods with PCG, in order to comply with requirements pursuant to the MyCare Ohio 1915(c) approved waiver and OAC 5160-58-05.3.

56. Pursuant to O.R.C. 5167.14, the MCOP must enter into a data security agreement with the State of Ohio’s Board of Pharmacy that governs the MCOP’s use of the Board’s drug database established and maintained under O.R.C. 4729.75.
57. Upon request by ODM, the MCOP must share data with ODM’s actuary. ODM and the MCOP are covered entities under HIPAA. ODM represents and warrants that separate from this Provider Agreement, a Business Associate agreement that complies fully with HIPAA and the Health Information Technology for Economic and Clinical Health Act (“HITECH”) and the implementing federal regulations under both Acts, has been executed by Mercer, is currently in effect, and will remain in effect for the Term of this Agreement.
58. As outlined in OAC rules 5160-58-01.1 and 5160-26-05 and the Three-Way, MCOP subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).
59. The MCOP must comply with Executive Order 2011-12K. A copy of Executive Order 2011-12K can be found at <http://governor.ohio.gov/MediaRoom/ExecutiveOrders.aspx>. This Executive Order prohibits the use of public funds to purchase services that will be provided outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. Additionally, the MCOP must not transfer PHI to any location outside the United States or its territories.
60. The MCOP must hold and maintain accreditation by the National Committee for Quality Assurance (NCQA) for the Medicare or Medicaid line of business as specified in 2.2.4 of the Three-Way. The MCOP must achieve and/or maintain an Excellent, Commendable or Accredited status. If the MCOP receives a provision or denied status from NCQA, the MCOP will be subject to sanctions as noted in Appendix N. Compliance will be assessed annually based on the MCOP’s accreditation status as of September 15<sup>th</sup> of each year. Upon completion of the accreditation survey, the MCOP must provide any and all documents related to achieving accreditation upon ODM’s request as specified in 2.2.4 of the Three-Way.

61. Advisory Councils

The MCOP must comply with Section 2.9.5 of the Three-Way, and must report the following to ODM on the 15<sup>th</sup> of July, October, January and April of each calendar year:

- List of attending members during the prior quarter for each regional Consumer Advisory Board;
- Meeting dates, agenda and the minutes from each regional meeting that occurred during the prior quarter; and

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

62. Home and Community Based Services (HCBS) Waiver Requirements

- a. For reconciliation of existing waiver enrollees to the MyCare waiver, the MCOP must report to ODM any MyCare member for whom an active waiver span is indicated on the 834 file that documents any waiver but the MyCare Ohio waiver.
- b. Waiver Enrollment Reporting and Reconciliation – The MCOP must submit monthly waiver enrollment information to ODM, and must participate in an annual waiver enrollment reconciliation process at the end of each waiver year.

63. Payment/Adjustment to Capitation in Consideration of the ACA Section 9010 Health Insurance Providers Fee

The following applies only to MCOPs that are covered entities under Section 9010 of the Patient Protection and Affordable Care Act, as amended by Section 10905 of the same Act, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), and thus required to pay an annual fee ("Annual Fee") for United States health risks.

Beginning in calendar year 2014, the ACA requires the MCOP to pay the Annual Fee no later than September 30th (as applicable to each relevant year, the "Fee Year") with respect to premiums paid to the MCOP in the preceding calendar year (as applicable to each relevant year, the "Data Year"), and continuing similarly in each successive year.

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

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

- The amount of the Annual Fee attributable to this Agreement;
- The corporate income tax liability, if any, that the MCOP incurs as a result of receiving ODM's payment for the amount of the Annual Fee attributable to this Agreement; and
- Any Ohio state and local Sales and Use taxes and Health Insuring Corporation taxes.

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

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

- Total premiums reported on IRS Form 8963;
- Ohio Medicaid-specific premiums included in the premiums reported on Form 8963;
- The amount of the Annual Fee as determined by the IRS; and
- The corporate income tax rate applicable to the year of such payments.

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

This provision shall survive the termination of the Agreement.

#### 64. Assisting Members in Finding Individual Providers

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

## **APPENDIX D**

### **ODM RESPONSIBILITIES**

The following are the Ohio Department of Medicaid (ODM) responsibilities or clarifications that are not otherwise specifically stated in OAC Chapter 5160-26, 5160-58 or elsewhere in the ODM MyCare Ohio Plan (MCOP) Provider Agreement.

#### General Provisions

1. ODM will provide MCOPs with an opportunity to review and comment on the rate-setting time line and proposed rates, and proposed changes to the OAC program rules and the provider agreement.
2. ODM will notify MCOPs of managed care program policy and procedural changes and, whenever possible, offer sufficient time for comment and implementation.
3. ODM will provide regular opportunities for MCOPs to receive program updates and discuss program issues with ODM staff.
4. ODM will provide technical assistance sessions where MCOP attendance and participation is required. ODM will also provide optional technical assistance sessions to MCOPs, individually or as a group.
5. ODM will provide MCOPs with linkages to organization(s) that can provide guidance on the development of effective strategies to eliminate health disparities.
6. ODM will conduct an annual analysis of Medicaid eligible individuals to identify whether there are any prevalent common primary languages, other than English, in an MCOP's service area. ODM will notify the MCOP of any languages that are identified as prevalent for the purpose of translating marketing and member materials.
7. ODM will provide each MCOP with an annual MCOP Calendar of Submissions outlining major submissions and due dates.
8. ODM will identify contact staff, including the Contract Administrator (CA), selected for each MCOP.
9. ODM will provide each MCOP with an electronic Provider Master File containing all the Ohio Medicaid fee-for-service (FFS) providers, which includes their Medicaid Provider Numbers, as well as all providers who have been assigned a provider reporting number for current encounter data purposes. This file will also include NPI information when available.

10. Consumer Information

- a. ODM, or its delegated entity, will provide membership notices, informational materials, and instructional materials to members and eligible individuals in a manner and format that may be easily understood. At least annually, ODM or its designee will provide current MCOP members with an open enrollment notice which describes the MyCare Ohio program and includes information on the MCOP options in the service area and other information regarding the MyCare Ohio program.
- b. ODM will notify members or ask MCOPs to notify members about significant changes affecting contractual requirements, member services or access to providers.
- c. If an MCOP elects not to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, ODM will provide coverage and reimbursement for these services for the MCOP's members. As applicable, ODM will provide information to the MCOP's members on what services the MCOP will not cover and how and where the MCOP's members may obtain these services.

11. Membership Selection and Premium Payment

- a. The Medicaid Consumer Hotline (henceforth referred to as the "Hotline") - The ODM-contracted Hotline is responsible for providing unbiased education and selection services for the Medicaid managed care program. The Hotline operates a statewide toll-free telephone center to assist eligible individuals in selecting an MCOP or choosing a health care delivery option.
- b. Auto-Assignment Eligible individuals that fail to select a plan will be assigned to an MCOP at the discretion of ODM.
- c. Consumer Contact Record (CCR): ODM or their designated entity shall provide CCRs to MCOPs on no less than a weekly basis. A CCR is a record of each consumer-initiated MCOP enrollment, change, or termination, and each Hotline-initiated MCOP assignment processed through the Hotline.
- d. ODM verifies MCOP enrollment via a membership roster. ODM or its designated entity will provide a full member roster (F) and a change roster (C) via HIPAA 834 compliant transactions.
- e. Monthly Premiums - ODM will remit payment to the MCOPs via an electronic funds transfer (EFT), or at the discretion of ODM, by paper warrant.
- f. Remittance Advice (RA) - ODM will confirm all premium payments paid to the MCOP during the month via a monthly RA. ODM or its designated entity will provide a record of each recipient detail level payment via HIPAA 820 compliant transactions. ODM or its

- designee will keep a record of each MCOPs Accounts Payable (e.g. Pay 4 Performance, and Health Insurance Provider Fee) and Accounts Receivable (e.g. Penalty, Credit Balance) transaction on the MITS Provider Portal Report Tab.
- g. ODM will provide optional dual benefits enrollment and will not require mandatory Medicaid only enrollment for individuals who are determined eligible for County Board of Developmental Disabilities Services.
12. ODM will make available a website which includes current program information.
  13. ODM will regularly provide information to MCOPs regarding different aspects of MCOP performance including, but not limited to, information on MCOP-specific and statewide external quality review organization surveys, focused clinical quality of care studies, consumer satisfaction surveys and provider profiles.
  14. Communications - The Bureau of Managed Care (BMC) is responsible for the oversight of the MCOPs' provider agreements with ODM. Within the BMC, a specific Contract Administrator (CA) has been assigned to each MCOP. Unless expressly directed otherwise, an MCOP shall first contact its designated CA for questions/assistance related to Medicaid and/or the MCOP's program requirements /responsibilities. If its CA is not available and the MCOP needs immediate assistance, MCOP staff should request to speak to a supervisor within the Managed Care Contract Administration Section.

**APPENDIX E**  
**RATE METHODOLOGY**



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# July 2016 MyCare Ohio Provider Agreement Rate Amendment Summary

## Opt-In Capitation Rates

July 1, 2016 through December 31, 2016

## Ohio Department of Medicaid

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**Attachment 1:** Certified Rates

## I. INTRODUCTION

This document is an abridged version of the capitation rate amendment entitled *July 2016 MyCare Capitation Rate Amendment Opt-In Capitation Rates* and delivered to the Ohio Department of Medicaid (ODM) on June 3, 2016. For a complete version, please reference the specified document.

### Background

Milliman, Inc. (Milliman) has been retained by the ODM to provide actuarial and consulting services related to the development of capitation rates for its MyCare Ohio (MyCare) dual eligible managed care program. ODM, along with CMS and the MyCare Ohio plans (MCOPs), provides benefits for fully dual eligibles under the MyCare Ohio program within targeted geographic areas. This letter provides an amendment to the certified calendar year (CY) 2016 capitation rates for effective dates beginning July 1, 2016.

This report is an amendment to the documentation of the capitation rates developed for CY 2016. The previously certified capitation rates and the documentation of the development were published in the following correspondence provided by Milliman:

- *Calendar Year 2016 MyCare Ohio Capitation Rate Certification Opt-In Capitation Rates* dated December 10, 2015 (Original)

We have updated the capitation rates provided in the Original certification to reflect Ohio's disability determination methodology conversion from the status of a 209(b) to a 1634 state (including creation of a 1915(i) state plan option). Capitation rates have additionally been updated for Nursing Facility (NF) policy changes, fee schedule increase for RN and LPN nursing services within the Home Health, PDN and Waiver categories of services and an increase to care management costs for Waiver enrollees ages 60 and over. **Unless otherwise stated, the methodology and assumptions utilized are consistent with the capitation certification documentation included in the Original report.**

### General Information

The capitation rates provided with this certification are "actuarially sound" for purposes of 42 CFR 438.6(c), according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- The capitation rates meet the requirements of 42 CFR 438.6(c).

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Federal regulation 42 CFR §438.6(c).
- *2016 Medicaid Managed Care Rate Development Guide* published by CMS on September 23, 2015.
- Throughout this document, the term "actuarially sound" will be defined in ASOP 49:

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

## II. EXECUTIVE SUMMARY

### Summary of Methodology

The methodology used in developing the July 1, 2016 amendment to the certified CY 2016 capitation rates is outlined below.

#### ***Step 1: Base Experience***

We used the projected claims data underlying the CY 2016 MyCare capitation rates, as outlined in the Original certification, as base experience for developing the July 1, 2016 capitation rates. These projected claims costs are inclusive of all retrospective, prospective, trend, managed care efficiency, Opt-In versus Opt-Out selection and other claims cost adjustments made to the data as outlined in the Original certification.

#### ***Step 2: Adjustments for prospective program and policy changes***

The base experience is adjusted for known policy and program changes that are expected to be implemented in July through December 2016. This includes Ohio's conversion from the status of a 209(b) to a 1634 state including creation of a 1915(i) state plan option and the impact of discontinuing the spend down program. Adjustments have additionally been made to NF, Home Health, Private Duty Nursing and Waiver Nursing services fee schedules. Documentation of items requiring the calculation of adjustment factors is provided in this report. Adjustments are applied to the base experience data to reflect program changes not included in the Original certification. The resulting values establish the adjusted claim cost by population group and region for the contract period.

#### ***Step 3: Data smoothing for non-credible sub-populations***

Regional and age-based rating factors are developed consistent with the methodology in the Original certification as a data smoothing methodology for non-credible sub-populations.

#### ***Step 4: Inclusion of care management costs***

Care management is included in a separate service category as a single adjustment to costs. The care management costs represent the combination of two types of care management: AAA + plan management for waiver-eligible enrollees age 60 years and older, and other plan management for the remaining population groups. The care management costs for the AAA + plan management for waiver-eligible enrollees age 60 years and older have been updated to reflect data gathered from a recent care management survey completed by the MCOPs. Care management costs have not been revised for any population other than waiver-eligible enrollees ages 60 years and older.

#### ***Step 5: Incorporate non-claim items and adjustments***

The adjusted claim cost are modified to include the impact of certain non-benefit items, such as administrative expenses, risk margin, taxes and the 2% integrated care joint savings percentage for the Opt-In rates (corresponding to Demonstration Year 2). No changes were made to non-claim assumptions from the values included in the Original certification. The Consolidated Appropriations Act of 2016, signed on December 18, 2015, includes a moratorium of the ACA Health Insurer Provider Fee (HIPF) for 2017. As a result, 2016 MyCare-certified capitation rates are no longer expected to be adjusted for the HIPF.

#### ***Step 6: Development and issuance of actuarial certification***

An actuarial certification is included and signed by Jeremy D. Palmer, FSA, a Principal and Consulting Actuary in the Indianapolis office of Milliman, Inc. Mr. Palmer meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, in order to certify that the final rates meet the standards in 42 CFR §438.6(c).

The certified Opt-In capitation rates by rate cell with and without the 2016 quality withhold are illustrated in Attachment 1. The rates are effective from July 1, 2016 through December 31, 2016.

### III. PROSPECTIVE DATA ADJUSTMENTS

#### Program Adjustments – July 2016

Adjustment factors for the July 1, 2016 MyCare rate amendment were developed for the following policy and program changes, known as of the date of this letter.

#### 209(b) to 1634 Conversion

Effective August 1, 2016, Ohio will convert their disability determination methodology from the status of a 209(b) to a 1634 state. Under the 1634 conversion, Ohio will extend Medicaid eligibility to all individuals who receive Supplemental Security Income (SSI). Individuals with SSI will be automatically enrolled in Medicaid. Additionally, Ohio will use the same definition for Medicaid eligibility coverage as the Social Security Administration. This will effectively increase the Federal Poverty Level income standard from 64% to 75%.

Additionally, on July 31, 2016, ODM will eliminate the existing Medicaid spend down program. A 1915(i) state plan option will create a special benefit program for adults 21 years of age and older with severe and persistent mental illness (SPMI) with income up to 225% of the federal poverty level that would not otherwise be eligible for Medicaid.

To ensure that impacted members have sufficient time to transition to other coverage sources, there will be a pause in redetermination. The following categories identify the intended eligibility status for MyCare potential enrollees. Ultimately, we anticipate no significant changes in MyCare enrollment distribution or acuity through December 2016.

#### **Current MyCare Dual Enrollees as of July 31, 2016**

Recurring spend downs – Enrollees remain in MyCare with MCOP paying prior spend down component until first redetermination on or after January 1, 2017 at which time continued MyCare eligibility is subject to 1634/1915(i) criteria.

All others – Enrollees remain in MyCare until first redetermination on or after January 1, 2017 at which time continued MyCare eligibility is subject to 1634/1915(i) criteria.

#### **Current Medicaid Dual Enrollees in MyCare Region but not MyCare as of July 31, 2016**

Non-recurring spend downs – Individuals who have met at least one month of spend down criteria in the past twelve months will become fully Medicaid eligible in fee-for-service (FFS) until at least December 31, 2016. Medicaid eligibility will be reviewed at first redetermination on or after January 1, 2017. Enrollees will shift to MyCare on January 1, 2018 if eligibility is retained during calendar year 2017 redetermination.

#### **In MyCare Region but Not Medicaid as of July 31, 2016**

Currently receiving SSI as of July 31, 2016 – Individuals become Medicaid FFS eligible on August 1, 2016 and transition to MyCare on August 1, 2017 subject to retaining 1634 status or meeting 1915(i) criteria at redetermination.

SSI application/approval on or after 8/1/2016 – Individuals become MyCare eligible immediately upon meeting 1634 criteria.

1915(i) application on or after 8/1/2016 – Individuals become FFS eligible following 1915(i) approval, transition to MyCare at first redetermination after January 1, 2017.

## Elimination of Spend Down

As mentioned under “Recurring spend downs” in the section above, elimination of spend down eligibility will temporarily result in additional cost to the MCOPs for certain Community Well MyCare enrollees. Specifically, recurring spend downs will become fully eligible under MyCare effective August 1, 2016 through their first redetermination on or after January 1, 2017. Thus, payment amounts that were previously the responsibility of the recurring spend down enrollees will no longer be collectable from the enrollees.

## 1915(i) - Specialized Recovery Services

Effective August 1, 2016, ODM is providing specialized recovery services (SRS) to individuals enrolled in Medicaid through the 1915(i) waiver. The planned delay in redetermination, along with timing needs for implementation of assessments and contracting of services, will significantly limit the number of individuals receiving SRS services under the 1915(i) waiver during the period of August 2016 through December 2016.

## Nursing Facility

### Per Diem Update

NF per diems will be rebased effective July 1, 2016. Along with the rebasing, ODM will be updating the resource utilization group (RUGs) methodology used to measure resident acuity. The methodology will be updated from RUGS III to RUGS IV to coincide with the calculation of new rate components during the rebasing process. Based upon detailed data provided by ODM, the rebasing and group update increase the original CY 2016 per diems for all regions except the Southwest region for which per diems are expected to decrease. The July 2016 rate amendment reflects the impact of the updated NF per diems on NF crossover, NF non-crossover and hospice room and board services.

### Peer Group Change

Along with the per diem update, Trumbull County will be reassigned from Peer Group 3 to Peer Group 2. The change in peer group in Trumbull County is expected to increase average per diems in the Northeast Central region.

### Reduced Reimbursement for Low Acuity Individuals

As of July 1, 2016, the gross daily rate paid for the lowest acuity individuals in Ohio's NFs (PA1 and PA2) will be reduced from \$130.00 per resident day to \$115.00 per resident day to more closely correspond with the expected cost of serving these individuals.

## Home Health, PDN and Waiver Nursing Services

Effective October 1, 2016, ODM will increase fees for G0154, T1000, T1002 and T1003 by an average 6% corresponding to approximately \$600,000 in additional MyCare expenditures through December 31, 2016.

## IV. CAPITATION RATE DEVELOPMENT

### Data Smoothing

Consistent with the data smoothing in the Original certification, regional and population group rating factors are developed and utilized as a data smoothing technique for low credibility region and population combinations. The smoothed rates form the cost basis for the final capitation rates.

### Care Management Costs

Care management is included as a separate service category as a single adjustment to costs. The care management costs represent the combination of two types of care management: AAA+ plan management for waiver-eligible enrollees age 60 years and older and other plan management for the remaining populations groups. As stated in the three way contract between ODM, CMS, and the MCOPs, the MCOPs are required to contract with AAAs to perform waiver service coordination for, at a minimum, individuals age 60 years and older. The AAA+ plan management costs for waiver-eligible enrollees age 60 years and older are increased by 9.0% over the Original certification to reflect data gathered from a care management survey completed by the MCOPs. Care management costs are not revised for any population other than waiver-eligible enrollees age 60 years and older.

### Administration and Other Non-Benefit Adjustments

Consistent with the Original certification, the adjusted claim cost are modified to include the impact of certain non-benefit items, such as administrative expenses, risk margin, taxes and the 2% integrated care joint savings percentage for the Opt-In rates (corresponding to Demonstration Year 2). No changes are made to non-claims assumptions from the values included in the Original certification.

## V. MEMBER ENROLLMENT MIX ADJUSTMENT (MEMA)

The MEMA provides an update of the rates to reflect the risk mix of enrollees in each MCOP compared to the mix that was used in the capitation rate development. Specifically, the MEMA addresses the relative risk/cost differences of the population groups that make up the NFLOC rate cell. The population groups within the NFLOC rate cell provide a proxy for assessment of risk differences among the MCOPs. The MEMA allocates additional revenue to plans covering a higher proportion of high risk individuals (Institutional and Community Waiver 18 - 44) and less revenue for plans covering a higher proportion of lower cost individuals (Community Waiver 45 - 64 and Community Waiver 65+). The MEMA is a budget-neutral adjustment which will be updated January and July of each year.

- April 2016 MyCare enrollment data will be used for the July 1, 2016 through December 31, 2016 MEMA development

## VI. LIMITATIONS AND DATA RELIANCE

The information contained in this report has been prepared for ODM to provide documentation of the development of the July 1, 2016 amendment to the certified Calendar Year 2016 MyCare Ohio capitation rates for the Opt-In Population. The data and information presented may not be appropriate for any other purpose.

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

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

Milliman has relied upon certain data and information provided by ODM and the participating MCOPs in the development of the July 1, 2016 capitation rate amendment. Milliman has relied upon ODM and the MCOPs for the accuracy of the data and accept it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

The services provided by Milliman to ODM were performed under the signed contract agreement between Milliman and ODM dated June 11, 2015.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

## ATTACHMENT 1

**Ohio Department of Medicaid  
MyCare Managed Care Program  
July 2016 - December 2016 Opt-In Certified Rates**

<b>Population Group:</b>	<b>NFLOC Total</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 4,094.90	\$ 81.90	\$ 4,013.00
East Central	3,336.56	66.73	3,269.82
Northeast	3,881.64	77.63	3,804.01
Northeast Central	3,737.57	74.75	3,662.82
Northwest	3,584.78	71.70	3,513.08
Southwest	3,836.25	76.73	3,759.53
West Central	3,294.14	65.88	3,228.26
<b>Statewide Total</b>	<b>\$ 3,697.78</b>	<b>\$ 73.96</b>	<b>\$ 3,623.82</b>

<b>Population Group:</b>	<b>Community Well 18-44</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 428.08	\$ 8.56	\$ 419.52
East Central	261.97	5.24	256.74
Northeast	314.69	6.29	308.40
Northeast Central	224.29	4.49	219.81
Northwest	300.83	6.02	294.81
Southwest	273.55	5.47	268.08
West Central	291.13	5.82	285.30
<b>Statewide Total</b>	<b>\$ 303.43</b>	<b>\$ 6.07</b>	<b>\$ 297.36</b>

<b>Population Group:</b>	<b>Community Well 45-64</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 539.87	\$ 10.80	\$ 529.07
East Central	323.63	6.47	317.15
Northeast	391.13	7.82	383.30
Northeast Central	274.38	5.49	268.89
Northwest	374.16	7.48	366.68
Southwest	338.19	6.76	331.43
West Central	361.08	7.22	353.86
<b>Statewide Total</b>	<b>\$ 380.07</b>	<b>\$ 7.60</b>	<b>\$ 372.47</b>

<b>Population Group:</b>	<b>Community Well 65+</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 799.66	\$ 15.99	\$ 783.66
East Central	825.28	16.51	808.78
Northeast	652.91	13.06	639.85
Northeast Central	656.80	13.14	643.66
Northwest	603.69	12.07	591.62
Southwest	834.81	16.70	818.11
West Central	869.89	17.40	852.49
<b>Statewide Total</b>	<b>\$ 731.14</b>	<b>\$ 14.62</b>	<b>\$ 716.51</b>



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# Calendar Year 2016 MyCare Ohio Provider Agreement Rate Summary

Opt-In Capitation Rates

January 1, 2016 through December 31, 2016

Ohio Department of Medicaid

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**ATTACHMENT 1: CERTIFIED RATES**

## INTRODUCTION

This document is an abridged version of the capitation rate certification entitled *Calendar Year 2016 Ohio Capitation Rate Certification Opt-In Capitation Rates January 1, 2016 through December 31, 2016* and delivered to the Ohio Department of Medicaid (ODM) on December 10, 2015. For a complete version, please reference the specified document.

## BACKGROUND

Milliman, Inc. (Milliman) has been retained by ODM to provide actuarial and consulting services related to the development of the calendar year 2016 (demonstration year 2) capitation rates for MyCare Ohio. MyCare Ohio is Ohio's managed care program for the dual eligible (Medicare-Medicaid) population. Eligible individuals are required to either receive both Medicare and Medicaid services (Opt-In) or Medicaid services only (Opt-Out) through the managed care plan. Enrollees who select to Opt-In become Integrated Care Delivery System (ICDS) participants in the Dual Demonstration program.

This letter provides the development of the actuarially sound calendar year 2016 capitation rates for Opt-In individuals. Unless otherwise specified, all references to "rates" or "capitation rates" throughout this document refer to the Medicaid-specific component of the MyCare Ohio capitation rates.

To facilitate review, this document has been organized in the same manner as the 2016 Managed Care Rate Setting Consultation Guide (2016 guide), released by CMS in September 2015.

## CERTIFIED CAPITATION RATES

The certified Opt-In capitation rates by rate cell with and without the 2016 quality withhold are illustrated in Attachment 1. The rates are effective from January 1, 2016 through December 31, 2016.

## SECTION I. MEDICAID MANAGED CARE RATES

### 1. GENERAL INFORMATION

This section provides information listed under the General Information section of the 2016 Managed Care Rate Setting Consultation Guide (2016 guide), Section I.

The capitation rates provided with this certification are “actuarially sound” for purposes of 42 CFR 438.6(c), according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- The capitation rates meet the requirements of 42 CFR 438.6(c).

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date
- Federal regulation 42 CFR §438.6(c).
- *2016 Medicaid Managed Care Rate Development Guide* published by CMS on September 23, 2015.
- Throughout this document, the term “actuarially sound” will be defined consistent with ASOP 49:

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

### A. ANNUAL BASIS

The actuarial certification contained in this report is effective for the capitation rates for the one year rate period from January 1, 2016 through December 31, 2016.

### B. DOCUMENTATION

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

### C. INDEX

The index to this rate certification is the table of contents, found immediately after the title page. The index includes section numbers and related page numbers. Sections not relevant to this certification continue to be provided, with an explanation of why they are not applicable.

## D. REQUIRED ELEMENTS

### i. Actuarial certification

The actuarial certification was signed by Jeremy D. Palmer, FSA, MAAA. Mr. Palmer meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certify that the final rates meet the standards in 42 CFR §438.6(c).

### ii. Certified rates

The certified Opt-In capitation rates by rate cell with and without the quality withhold are illustrated in Attachment 1. These rates represent the contracted capitation rates prior to risk adjustment.

### iii. Capitation rate ranges for each rate cell

### iv. Program information

#### (a) Managed care program

ODM, along with CMS and the MyCare Ohio plans (MCOPs), provides benefits for fully dual eligibles under the MyCare Ohio program within targeted geographic areas. This letter provides the documentation and certification of the calendar year 2016 capitation rates for the Medicaid component of the MyCare Ohio program for Opt-In individuals.

MyCare Ohio began a phased-in schedule of enrollment starting in May 2014 among 5 full-risk managed care plans in 7 regions. Demonstration Year 1 was comprised of the partial year 2014 and the complete calendar year 2015 time periods.

Separate rates were developed for Opt-In versus Opt-Out enrollees. The rates vary based upon enrollee selection assumptions and the 2% integrated care joint savings percentage for the Opt-In population for Demonstration Year 2 as identified in the three-way contract between ODM, CMS, and the MCOPs.

The services provided under this contract include complete physical and behavioral health, and long-term services and supports. The program pays secondary to Medicare for Medicare covered services.

#### (b) Rating period

This actuarial certification is effective for the one year rating period January 1, 2016 through December 31, 2016.

#### (c) Covered populations

The MyCare Ohio eligible population includes all “full benefit” Medicare and Medicaid enrollees age 18 and over within the selected MyCare demonstration counties. The following describes the populations **not** eligible to participate in the MyCare program:

- Partial Medicare Eligibility
- Delayed and Other Spend-down
- PACE
- Intellectual Disabilities and Other Developmental Disabilities (IDD)
- Receives Third-Party Liability (TPL) Benefits
- CMS Independence at Home (IAH) Demonstration
- Employee Union Coverage and/or Retiree Drug Subsidy
- Incarcerated Recipients
- Other Exclusion Populations.

#### (d) Eligibility criteria

Enrollment in MyCare is mandatory for eligible individuals. Eligible individuals are required to either receive both Medicare and Medicaid services (Opt-In) or Medicaid services only (Opt-Out) through the managed care plan. Enrollment occurs on

a passive basis such that eligible members must specify their decision to Opt-Out. Enrollees who remain Opt-In become Integrated Care Delivery System (ICDS) participants in the Dual Demonstration program.

### **(e) Covered services**

Covered services are split into three service groupings: crossover services, non-crossover services, and waiver services based upon category of service logic.

## **2. DATA**

### **A. DESCRIPTION OF THE DATA**

#### **i. Description of the data**

##### **(a) Types of data**

The following experience served as the primary data sources for the calendar year 2016 MyCare Ohio capitation rate development:

- Fee for service (FFS) data for the MyCare eligible population for May 1, 2013 through April 30, 2014 (base data year)
- Calendar year (CY) 2014 and YTD June 2015 MCOP cost reports (financial summaries) – reference only

##### **(b) Age of the data**

The data used to develop the capitation rates is primarily from May 1, 2013 through April 30, 2014. The data is reported with claims run-out through August 31, 2015. The entire base data year is prior to implementation of managed care for the MyCare population.

##### **(c) Data sources**

The historical FFS data used as a primary data source for this certification was provided by ODM through the monthly vendor files. The vendor files are developed and maintained by Hewlett Packard (HP), ODM's fiscal agent.

The MCOP financial summaries were submitted to ODM and Milliman by each plan. The financial summaries were used as reference only to inform our actuarial judgment of the assumptions used to adjust and project the capitation rates.

##### **(d) Sub-capitation**

The FFS base data does not include sub-capitation amounts.

#### **ii. Availability and quality of the data**

##### **(a) Steps taken to validate the data**

The majority of the data used in this certification is fee-for-service data provided by the fiscal agent. The fiscal agent, HP, is primarily responsible for ensuring the accuracy and completeness of the fee-for-service claims data. ODM and Milliman monitor claims data monthly to identify inconsistencies in the data and work with HP to validate the claims and enrollment information.

Additionally, ODM and Milliman collect quarterly cost reports (financial summaries) from the MCOPs. These reports reflect the MCOP's estimate of membership, incurred claims, administrative costs, and revenue by region and rate cell. The base FFS data was compared to the cost reports where applicable for consistency.

### **(b) Actuary's assessment**

As required by Actuarial Standard of Practice No. 23, Data Quality, we disclose that we have relied upon certain data and information provided by ODM and their vendors, primarily the MCOPs and ODM's fiscal agent. The certification is dependent upon this reliance.

The FFS data represents the most appropriate data to be used for developing the actuarially sound capitation rates for the CY 2016 MyCare program. The MCOP cost reports are believed to be useful for reference purposes only as opposed to explicit base data. The cost reports contain indications of MCOP costs and are used to inform assumptions used to adjust the FFS data.

The MCOP encounter data is not of sufficient quantity or quality to be relied upon for the development of actuarially sound capitation rates.

### **(c) Data concerns**

We have not identified any material concerns with the quality or availability of the FFS data. The only concern is that it requires additional assumptions and adjustments to reflect the coverage and service delivery of the MyCare managed care program.

#### **iii. Use of encounter and fee-for-service data**

We confirm that FFS claims and enrollment were used as the primary data source for this certification. The base data used reflects the historical experience and covered services most closely aligned with the MyCare program.

#### **iv. Use of managed care encounter data**

Encounter data was not used for this certification. The MCOP encounter data is not of sufficient quantity or quality to be relied upon for the development of actuarially sound capitation rates. The program began in May 2014 and the encounter data has not been validated. While validation efforts continue, there remain numerous reporting issues for many MCOPs that have not been resolved.

## **B. DATA ADJUSTMENTS**

Capitation rates were developed from historical FFS data, incurred from May 1, 2013 to April 30, 2014, and paid through August 31, 2015. The primary base data year adjustments include completion adjustments, reimbursement adjustments, and other program adjustments.

### **i. Credibility adjustment**

The MyCare eligible populations, in aggregate, were considered fully credible. No adjustments were made for credibility in the aggregate; however we did implement data smoothing among population groups and regions as discussed in a later section of this report.

### **ii. Completion adjustment**

The base data year includes 12 months of incurred claims, with 16 additional months of claim payments. To develop the completion factors, we used an additional 16 months of earlier historical experience. This allowed us to analyze payment completion patterns in the earlier experience and apply it to the base year data.

### **iii. Errors found in the data**

No material errors were found in the data.

#### iv. Program change adjustments

The base data year represents a historical time period from which projections were developed. We reviewed prior rate setting documentation and other materials from ODM to identify program changes that were implemented during the base data period. To the extent the program adjustments were estimated to have a material impact on MCOP service or administrative costs, an adjustment was considered for the calendar year 2016 rate development process. Adjustments were made to the portion of the base data prior to the implementation of each program change in order to ensure the entire base period was on a consistent basis. Relevant historical program changes are discussed below. Program changes have been grouped into three categories: nursing facility (NF), HCBS waivers, and other medical, as summarized below. Other base data year changes are also described.

##### ***Nursing Facility***

- ***NF Rate Changes – Various Effective Dates***

The NF adjustments include the impact of the semi-annual per diem case mix updates through January 2014 as well as the additional policy changes listed below. All NF analyses (policy changes and trend analysis) were performed separately for gross claims payments versus patient liability.

- NF Change to Peer Group for Stark and Mahoning Counties – October 1, 2013
- Update to base rate components inclusive of the impact of unbundling of select services – January 1, 2014

##### ***HCBS Waiver Services***

- ***Ohio Department of Aging (ODA) Waiver Services Fee Increase – July 1, 2013***

Effective July 1, 2013, ODM increased the reimbursement for certain Ohio Department of Aging (ODA) waiver services.

- ***Waiver Consolidation (MyCare Members Only) – March 1, 2014***

The implementation of MyCare included the consolidation of existing waiver programs into the MyCare Waiver. Prior to MyCare implementation, members were assessed for needs and assigned a specific waiver program. MyCare now provides eligibility for all services under the MyCare waiver, instead of only the services specific to the waiver program a member would have been assigned to previously.

- ***Elimination of Cost Cap from ODA Waivers (MyCare Members Only) – March 1, 2014***

Prior to elimination of the cost cap, to be eligible for PASSPORT and Choices waivers, projected waiver costs must be no greater than 60% of the cost of institutionalization. Under MyCare, this requirement has been removed.

##### ***Other Medical Services***

- ***Medicare Coinsurance Decrease for Behavioral Health Treatment Services***

Medicare recipients are responsible for coinsurance payments for behavioral health treatment services, which for dual eligibles is covered by Medicaid. Prior to 2010, Medicare coinsurance for behavioral health services was 50%. Starting in 2010, the coinsurance level began to grade-down to 20%, which is consistent with typical Part B cost sharing. Ohio Medicaid provides coverage for the recipient coinsurance amounts for these services. Cost adjustments were calculated for the behavioral health and some physician crossover services.

- ***Outpatient Unlisted Codes***

Effective January 1, 2014, ODM adopted a percentage of cost payment structure instead of reimbursing hospitals for certain outpatient services at 100% of cost.

- ***Inpatient Hospital APR-DRG Reimbursement Adjustments***

Beginning on July 1, 2013, ODM rebased its hospital base rates using All Patients Refined Diagnosis Related Groups (APR DRG). We evaluated the payment methodology change to APR-DRG for the MyCare program and found the impact to be immaterial. This is primarily a result of the Medicare primary benefit and the Medicare benefit design.

- ***Part B Crossover Payment Policy Change to Medicaid Maximum Payment***

For certain Part B services, ODM revised reimbursement to be the difference between the Medicaid allowed amount and the Medicare paid amount for those Part B services. The Medicaid maximum payment change was effective in January 1, 2014, with the exception of ambulatory surgery centers, dialysis clinics, and physician services. Prior to the Medicaid max payment methodology, ODM reimbursed up to the Medicare allowed amounts for all Part B services.

***Other Base Year Adjustments***

- ***Third-Party Liability***

The MyCare program eligibility requirements exclude individuals with third-party insurance coverage. This criteria eliminates the vast majority of third-party liability. Any remaining third-party liability was considered immaterial.

- ***Disproportionate Share Hospital (DSH) Payments***

The base data year FFS claims do not include DSH payments. Therefore, no adjustment was necessary to exclude these payments.

- ***Graduate Medical Education (GME) Payments***

The base data year FFS claims include payments secondary to Medicare for crossover services and primary for non-Medicare covered inpatient claims. The inpatient fee schedule includes GME payments as part of the prospective payment rate, and were therefore included in the data as part of the Medicaid payment. For crossover claims, GME will be included only to the extent (or proportion) that the Medicaid allowed is included in the payment.

- ***Patient Liability***

Members receiving LTSS may be required to contribute income towards their long-term care costs. This can be applied to both nursing facility and HCBS services. In general, the providers are collecting the patient liability directly and therefore these payments are removed from the calculation of the capitation rates. The exception to this is for legacy PASSPORT and Choices waiver individuals where the ODM collects the patient liability amounts. For these 2 cases, the capitation rates were not reduced by patient liability amounts.

- ***Blend of Traditional Medicare and Medicare Part C***

The historical base data year comprises FFS claims and enrollment from individuals that were either enrolled in traditional Medicare or Medicare Part C for their Medicare benefits. We considered a straight blend of this experience in the base data year, but for crossover services it was determined that traditional Medicare experience was the most appropriate base cost. This results from the variation in benefit design observed from Medicare Part C plans and the resulting Medicaid payment.

The adjusted base data year includes a member month weighted average of the Part C and Non-Part C experience for non-crossover and waiver services, and only Non-Part C for crossover services.

We applied a selection adjustment specific to the crossover services to reflect that Part C individuals were not included in the base data year because of our blending methodology.

- ***Fraud and Abuse Recoveries***

The base data year FFS claims already reflect the reduction for any amounts that have been identified and re-adjudicated or denied due to fraudulent activities. Additionally, we included a reduction of 0.25% to all services to reflect that there are additional recoveries not reprocessed through the claim system.

### 3. PROJECTED BENEFIT COST AND TRENDS

#### A. DEVELOPMENT OF PROJECTED BENEFIT COSTS

##### i. Description of the data, assumptions, and methodologies

The adjusted FFS base data year described in the previous section reflects benefits and program requirements as of the end of the data period (April 30, 2014). The following adjustments were applied to reflect the benefits and program requirements in CY 2016, including adjustments to reflect a managed care environment and trend to the midpoint of the effective period of the capitation rates.

##### (a) Prospective program changes

- ***Nursing Facility***

Aside from case mix changes, there have been no NF benefit or fee changes subsequent to January 2014. We have reflected the annualized impact of case mix changes in the trend assumptions so no prospective program adjustment is needed. As previously stated, the impact of case mix through January 2014 is included in the retrospective NF program adjustment.

- ***Dental Benefits and Fee Changes – January 1, 2016***

ODM has approved policy changes regarding the dental benefit and fee schedule, effective January 1, 2016.

- *Periodontal Scaling and Root Planning* - Dental benefits will be extended for periodontal scaling and root planning services.
- *Dental Fee Schedule Changes* - The dental fee schedule will increase for specific dental codes (primarily extractions and denture repair), but these increases do not apply to dental services provided in an FQHC.
- *Fee Schedule Increase for Rural Counties* - ODM will implement a 5% rural fee schedule differential across all CDT codes, determined by the county in which the provider is located.

- ***Nurse & Aide Service Rate Modernization – July 1, 2015***

Effective July 1, 2015, ODM instituted new services and reimbursement changes for nurse and aide services. These reimbursement and service changes impact both state plan home health / private duty nursing services and multiple waiver services.

- ***Home Health Aide Services – January 1, 2016***

The reimbursement for home health aide services paid under code G0156, other than those provided by an independent provider, were increased by 5% over the rate in effect on October 1, 2015.

- ***Non-Agency Home Health Nurse/Aide Overtime – January 1, 2016***

ODM received federal guidance requiring the payment of overtime by non-agency home health providers. This adjustment was calculated by reviewing claims on a weekly basis for the impacted procedures and providers. The list of impacted procedures and providers was provided by ODM. The overtime payment was only applied to the wage component of each procedure fee.

- ***Increase Medicaid Physician Rates – January 1, 2016***

Effective on January 1, 2016, ODM is increasing the reimbursement to physicians for certain procedures. The adjustment only impacts certain procedures and the amount by code varies. The impact of these reimbursement changes was calculated net of the impact of the change to the Medicaid maximum payment methodology.

- ***Reimbursement Refinements for Radiology Services – January 1, 2014***

Effective January 1, 2014, ODM modified its reimbursement policy for radiology services that occur when more than one radiology procedure is performed by the same provider or provider group for an individual patient on the same date. The adjustment for the modifications made to the reimbursement of radiology services is captured in the Radiology/Pathology/Laboratory service category of the repricing of physician services.

- ***Physician Crossover Policy Change to Medicaid Maximum Payment – January 1, 2016***

The crossover reimbursement for physician services reflected in the base data includes all Medicare allowed amounts not paid by Medicare. Effective January 1, 2016, ODM will make a program change to limit reimbursement to the Medicaid maximum amount rather than providing payment up to the Medicare allowed amount. Other Medicare Part B services transitioned to the Medicaid maximum payment methodology on January 1, 2014. Services associated with dialysis clinics and ambulatory surgical centers will continue to be exempt from Medicaid maximum policy changes.

The following crossover service categories were affected:

- Physician Services
- FQHC / RHC
- Optometric Services
- Radiology / Pathology / Laboratory
- Other Non-Waiver Services

- ***5% Outpatient Hospital Reimbursement Reduction – January 1, 2016***

Effective January 1, 2016, outpatient hospital facility reimbursement for all providers, with the exception of children's hospitals, will be reduced by 5%. Ambulatory surgical centers are not impacted by this reimbursement change. The impact of this reimbursement change was valued in coordination with the ongoing impact of the Medicaid maximum payment methodology.

- ***DRG-Exempt Reimbursement Adjustments – October 1, 2014***

Effective October 1, 2014, DRG-exempt hospitals were reimbursed for hospital services at 90% of the calculated cost-to-charge ratio for freestanding rehabilitation hospitals and freestanding long-term care hospitals. Prior to this date, these facilities were reimbursed at 100% of cost.

- ***Hospital-Administered Drugs – January 1, 2016***

As of January 1, 2016, when a hospital independently bills for prescription drugs, reimbursement will be based on ODM's fee schedule. To the extent the drug is not on the fee schedule, the drug will continue to be reimbursed at 60% of cost. The hospital-administered drug adjustment was calculated subject to the ongoing impact of Medicaid maximum payment methodology.

## **(b) Managed care efficiency adjustments**

Managed care adjustments primarily reflect the expected mix impact related to projected enrollment shifts between population group categories.

In addition to the mix impact, home health/private duty nursing in the Central/Southeast region was targeted based on significantly higher utilization compared to other regions. This pattern was also observed in the Aged, Blind, or Disabled (ABD) non-dual population before it was transitioned to mandatory managed care.

With respect to population enrollment shifts, we assumed that 1% of NF enrollment will shift in favor of HCBS for 2016. We further assumed that cost effective utilization improvements for waiver services (in a managed care environment compared to a FFS environment) would offset the influx of more costly enrollees into waivers due to the transition from NF.

Finally, expected savings from the integration of Medicare and Medicaid services for the Opt-In population are explicitly reflected as the 2% integrated care joint savings percentage referenced in the non-benefit and expenses adjustment section of the methodology letter.

### (c) Opt-In selection adjustments

We calculated adjustments to reflect the selection risk corresponding to the option of Opt-In versus Opt-Out for individuals in the MyCare program. These selection adjustments vary by population group and service category.

### (d) Data smoothing

Regional and population group rating factors were developed and utilized as a data smoothing technique for low credibility region and population combinations. For example, regional and population group cost relativities were developed from the combined data for all Community Waiver populations. The regional and population group cost relativities were utilized for the development of final Community Waiver 18 - 44, Community Waiver 45 – 64, and Community Waiver 65+ PMPM claims cost. This same process was separately applied to the Community Well non-aged populations and regions.

## ii. Material changes to the data, assumptions, and methodologies

The capitation rates calculated for CY 2016 reflect a complete rebasing of claims and assumptions compared to the CY 2015 capitation rates.

- FFS data remains the basis for the rate development, but the data period has been moved forward from 5/1/2009 - 4/30/2011 to 5/1/2013 - 4/30/2014.
- In the prior methodology, experience for individuals enrolled in Medicare Part C was excluded. The CY 2016 methodology fully reflects Medicare Part C claims and enrollment experience for non-crossover and waiver services and includes a selection adjustment to recognize the exclusion of Medicare Part C enrollee experience from base data for crossover services. Additional discussion of the blending of Non-Part C and Part C data is provided in Section 2.B.iv.
- The development of certain adjustment factors, for retrospective program and policy changes, has been revised to include analysis of actual claims experience subsequent to the program or policy changes.
- CY 2014 and YTD June 2015 MCOP cost reports (financial summaries) were reviewed for validation of updated assumptions.
- The impact of prospective program adjustments has been analyzed in coordination with the existing Medicaid maximum reimbursement logic where appropriate.
- All completion, trend, selection and managed care assumptions have been updated based upon analysis of the more recent FFS data.
- Assumptions dependent upon the MyCare enrollment distribution between Opt-In versus Opt-Out and between population groups have been updated with actual MyCare enrollment data.
- Administrative cost percentages have been modified to keep CY 2016 administrative costs consistent with CY 2015 on a PMPM basis for the combined MyCare Opt-In and Opt-Out rates.

## B. PROJECTED BENEFIT COST TRENDS

### i. Description of the data, assumptions, and methodologies

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (May 1, 2013 to April 30, 2014) to the CY 2016 rating period.

Total benefit cost trends were developed on a PMPM basis consistent with prior years' certifications. The move to a utilization and unit cost approach is expected once encounter data can be used as the basis for the data. While the trends are illustrated on a PMPM basis, they reflect primarily utilization and mix/intensity of services. Unit cost trend, with the exception of the impact of case mix on NF per diem rates, is primarily handled through the program changes to reflect expected 2016 reimbursement.

### (a) Data

The primary data source used in the development of the historical FFS trends includes 28 months of incurred claims beginning January 2012 and ending April 2014.

Data sources that were additionally referenced include:

- *National Health Expenditure (NHE) projections* developed by the CMS office of the actuary, specifically those related to Medicaid.
- Public capitation rate reports from other state programs. We collect and maintain certifications from other Milliman offices as well as states that make their documents publicly available.

### (b) Methodology

The FFS data was summarized by population group, service category, and service month. We normalized the experience for material program adjustments to reflect a consistent reimbursement and covered benefit structure. The resulting historical trends were summarized as a data point in our process.

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We also referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in this specific population, and shifting population mix. The annual trend assumptions include the limited impact of 2016 as a leap year. The impact is minimized by the fact that the trends are applied for 32 months which equates to an approximate 0.1% annualized impact.

## ii. Benefit cost trend components

Total benefit cost trends were developed on a PMPM basis consistent with prior years certifications. The move to a utilization and unit cost approach is expected once encounter data can be used as the basis for the data. While the trends are illustrated on a PMPM basis, they reflect primarily utilization and mix/intensity of services. Unit cost trend is generally handled through the program changes to reflect expected 2016 reimbursement.

## iii. Variation

The trends have been developed by service category. Trend variations between service categories reflect variation in the underlying historical experience and our actuarial judgment.

## iv. Material adjustments

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We also referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in this specific population, and shifting population mix.

We made adjustments to the trends derived from historical experience in cases where the resulting trends did not appear reasonably sustainable, or were not within consensus parameters derived from other sources.

## v. Any other adjustments

### (a) Impact of managed care

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost. The capitation rates have an explicit adjustment for the managed care adjustments.

### **(b) Trend changes other than utilization and unit cost**

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

## **C. IN LIEU OF SERVICES**

The projected benefit costs do not include costs for in lieu of services.

## **D. RETROSPECTIVE ELIGIBILITY PERIODS**

### **i. Health plan responsibility**

Under the MyCare contract, the health plans are not responsible for retrospective eligibility periods. Services during retrospective eligibility periods are provided on a fee-for-service basis.

### **ii. Base data treatment**

The historical FFS data includes all eligibility spans for a MyCare eligible individual, including retrospective eligibility. We worked with ODM in an attempt to identify such eligibility spans but there was not an appropriate identification. We discussed the implications with ODM and determined that we could not make an explicit adjustment for this program item. We believe that through review of the emerging experience of the MCOPs that our base claim cost is appropriate without a material adjustment for this item.

### **iii. Enrollment treatment**

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

## **4. PASS-THROUGH PAYMENTS**

This section is not applicable because there are no pass-through payments for the MyCare program. We assume that incentive payments, as listed in this section of the CMS rate consultation guide as a pass-through, were intended to indicate payments to medical or LTSS service providers and not incentive payments to the MCOP. Incentive payments available for MCOPs are documented in Section 7.

## **5. PROJECTED NON-BENEFIT COSTS**

### **A. DATA, ASSUMPTIONS AND METHODOLOGIES**

#### **i. Description of the data, assumptions, and methodologies**

##### **(a) Data**

The primary data sources used in the development of the CY 2016 non-benefit costs are listed below:

- Review of the cost reports (financial summaries) from the MCOPs covered under the MyCare contract.
- Assumptions employed by the previous actuary.
- Publicly available information for other state Medicaid programs.
- Actuarial judgment.

## (b) Assumptions and methodology

We summarized the historical cost report data against the assumptions employed in the current capitation rates. There appeared to be general consistency when looking at the care management and overall administrative costs reported by the MCOPs. As such, we established overall administrative costs that were similar on a composite PMPM equivalent basis to the current year assumptions.

### ii. Material changes

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

## B. NON-BENEFIT COSTS, BY COST CATEGORY

### i. Administrative costs

At the present time, the administrative cost has not been developed from the ground up (based on individual components). The components may appropriately interact, and ODM does not wish to dictate to the plans how these may be allocated.

The CY 2016 administrative cost allowance for MyCare is determined as a percentage of the capitation rates net of taxes and assessments. Administrative cost percentages have been modified to keep CY 2016 administrative costs consistent with CY 2015 on a PMPM basis for the combined MyCare Opt-In and Opt-Out rates.

### ii. Care coordination and care management

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

Plans are required to contract with Area Agencies on Aging (AAAs) to perform care management for members who are 60 years or older and on a waiver. The original rate component for AAA care management was developed under the previous certification and based on AAA cost report data. In addition to care management provided by AAAs, there is a plan component of care management included for each rate cell. The plan component for those 60 years or older is incorporated in the AAA rate.

One change from the previous year's actuarial certification was the removal of the SPMI health home component of the care management payment. These costs were explicitly added to the capitation rates in CY 2015 because the cost was not included in the base period experience. With the rebasing of data for CY 2016, these costs are included in our base data year. As such, we removed the explicit addition of this cost in the capitation rate development. We have assumed that all claims cost associated with health home services will be redirected on a budget neutral basis as the health home program phases out.

### iii. Provision for margin

The risk margin included in the CY 2016 MyCare capitation rates is 2.0% for each population group consistent with the margin assumption included in the CY 2015 rates.

### iv. Taxes, fee, and assessments

MCOPs are subject to a sales and use tax that varies by county. We obtained the tax rates by county from the State of Ohio website ([http://www.tax.ohio.gov/sales\\_and\\_use.aspx](http://www.tax.ohio.gov/sales_and_use.aspx)) and weighted the county-level tax amounts by August 2015 enrollment by county. MCOPs are also required to pay 1% of revenue for the Health Insuring Corporation (HIC) tax. The following table illustrates the sales and use tax and HIC tax by MyCare region.

### v. Other material non-benefit costs

Expected savings from the integration of Medicare and Medicaid services for the Opt-In population are explicitly reflected as the 2% integrated care joint savings percentage referenced in the non-benefit and expenses adjustment section of the methodology letter.

## C. PMPM VERSUS PERCENTAGE

The non-benefit cost for MyCare was developed as a percentage of the capitation rate for administrative costs and risk margin. Care management costs were developed on a PMPM basis.

## D. HEALTH INSURER FEE

### i. Whether the fee is incorporated in the rates

We have not included the health insurer fee into the capitation rates. We will restate the capitation rates at the time that the actual tax amounts are known and submit an amended capitation rate certification.

### ii. Fee year or data year

The amount to be added to the capitation rates will be based on a data year basis. For example, the 2016 capitation rates will be restated when the 2017 tax is due.

### iii. Determination of fee impact to rates

The amount to be added to the 2016 rates will be based on the actual fee for 2017 and actual tax impact of reimbursement of the fee.

### iv. Description of process

The calculation of the fee for each MCOP subject to the HIF will be based on the final Form 8963 premium amounts reported by the insurer, aggregate HIF premium base, final IRS invoices provided to the MCOPs subject to the HIF, Form 8963 premium amounts attributable to ODM, data year HIF tax percentage, and adjustments for premium revenue based on benefits described in 26 CFR 57.2(h)(2)(ix) such as nursing home and home health care. Final fee amounts are adjusted for applicable fees and taxes that are applied to ODM capitation rate revenue (documented in the non-benefit expense section of this report). The 2016 capitation rates will be amended based on the 2017 HIF attributable to the 2016 data year. We anticipate amending the rates in the last quarter of calendar year 2017.

### v. Excluded benefits

The long term care benefit costs associated with MyCare are extensive. This will significantly limit the amount of the MyCare revenue that is subject to the fee.

## 6. RATE RANGE DEVELOPMENT

This section is not applicable because rate ranges were not established for the MyCare program.

## 7. RISK MITIGATION AND RELATED CONTRACTUAL PROVISIONS

### A. DESCRIPTION OF RISK MITIGATION

The MyCare rates have been developed as full risk rates. The MCOPs assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract. The regional NFLOC rates will be prospectively adjusted by MCOP to reflect mix differences in the enrolling population between nursing facility and HCBS services. This adjustment will be made to the rates prospectively. No additional risk adjustment is planned for this population in CY 2016.

## **B. RISK ADJUSTMENT MODEL AND METHODOLOGY**

### **i. Risk adjustment model**

For the prospective member mix, we will continue to employ the Member Enrollment Mix Adjustment (MEMA). This methodology adjusts the NFLOC capitation rates based on a MCOPs mix of nursing facility and HCBS membership.

### **ii. Data and adjustments**

- The MEMA is a budget-neutral adjustment which will be updated January and July of each year.
- October 2015 MyCare enrollment data will be used for the January 1, 2016 through June 30, 2016 MEMA development
- April 2016 MyCare enrollment data will be used for the July 1, 2016 through December 31, 2016 MEMA development

### **iii. Changes from the prior year**

Aside from timing, there are no methodology changes from the prior year.

### **iv. Frequency**

MEMA factors will be calculated each six month period. The prospective adjustment will be made once prior to the beginning of the contract period and once in July 2016.

### **v. How the risk scores will be used to adjust the capitation rates**

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

### **vi. An attestation that the risk adjustment is cost neutral**

The MyCare MEMA is designed to be cost neutral. Relative adjustments will be normalized to result in an aggregate adjustment of 1.000 for each region, across all plans.

## **C. ADDRESS COST NEUTRALITY**

This section is not applicable to MyCare Ohio as the MEMA adjustment is designed to be budget neutral.

## **D. OTHER RISK SHARING ARRANGEMENTS**

No other risk sharing arrangements are proposed for the 2016 capitation rates.

## **E. MEDICAL LOSS RATIO**

### **i. Description**

The MCOPs have a target MLR of eighty-five percent (85%). The MLR calculation for the Opt-In shall be determined as defined in the 3-way contract.

## ii. Financial consequences

The MCOPs have a target MLR of eighty-five percent (85%). If an MCOP has an MLR between eighty-five percent (85%) and ninety percent (90%) of the joint Medicare and Medicaid payment to the MCOP, ODM and CMS may require a corrective action plan.

If an MCOP has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment, the MCOP must remit the amount by which the eighty-five percent (85%) threshold exceeds the MCOPs 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.

## F. REINSURANCE REQUIREMENTS AND EFFECT ON CAPITATION RATES

MyCare MCOPs are required to maintain minimum reinsurance protection as set out in the Ohio Administrative Code. Refer to the 3-way contract for specific requirements.

## G. INCENTIVES AND WITHHOLDS

### i. Incentives

There are no bonuses or incentives offered in the MyCare Ohio program.

### ii. Withholds

Withholds constitute 2% of the certified rates. The details of the quality metrics can be found in the 3-way contract for the Opt-In individuals. Attachment 1 illustrates the development of the guaranteed rates as a 2% reduction from the certified rates.

### iii. Estimate of percent to be returned

The MyCare program is new and the estimated amount of withhold return is uncertain.

### iv. Effect on the capitation rates

The rate is certified as actuarially sound assuming the withhold is not returned.

## 8. OTHER RATE DEVELOPMENT CONSIDERATIONS

### A. DIFFERENT FMAP

None of the MyCare population groups are eligible for an FMAP higher than the regular FMAP.

### B. ACTUARIALLY ACCEPTED PRACTICES AND PRINCIPLES

#### i. Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To our knowledge, there are no reasonable, appropriate, and attainable costs that have not been included in the certification.

## ii. Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process, with the exception of the budget neutral MEMA adjustment described in Section 7.

## iii. Rates within ranges

The final contracted rates will match the final certified capitation rates, with the exception of the budget neutral MEMA adjustment methodology, the capitation withholds, and the capitation incentives described in Section 7.

# 9. PROCEDURES FOR RATE CERTIFICATION AND CONTRACT AMENDMENTS

In general, a new rate certification will be submitted when the rates change materially. The following exceptions are noted:

1. A contract amendment that does not affect the capitation rates.
2. Risk adjustment, under a methodology described in the initial certification, changes the rates paid to the plans, but contracted rates still fall within the certified rate ranges for the contract period. Note that rate ranges were not employed for the MyCare program.

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

### 1. MANAGED LONG-TERM SERVICES AND SUPPORTS

#### A. COMPLETION OF SECTION I.

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

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

#### B. MLTSS RATE STRUCTURE

##### (a) Capitation Rate Structure

The MyCare Ohio rate structure for calendar year 2016 did not change from the 2015 rate structure. Rates continue to vary by region consistent with current geographic definitions. The NFLOC rate cell continues to reflect a composite of the institutional, community waiver 18 – 44, community waiver 45 – 64 and community waiver 65+ population groups. The NFLOC rate cell will be adjusted by the MEMA (discussed more in Section I7) on a semi-annual basis. The community well population groups includes three separate rate cells: community well 18 – 44, community well 45 – 64, and community well 65+ for a total of four MyCare Ohio rate cells.

##### Community Well

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

##### NFLOC

The NFLOC category represents MyCare-eligible members (as outlined earlier) who are eligible for or enrolled in one of the following populations:

- Ohio Medicaid HCBS waiver program
  - MyCare Waiver
  - Assisted Living
  - Choices (program has been discontinued, but was in place during FFS data period)
  - Ohio Home Care
  - PASSPORT
  - Transitions II (program has been discontinued, but was in place during FFS data period)
- Long-term nursing facility (NF) resident (i.e. institutional)
  - An individual must have 100 or more consecutive days in a NF based on Medicare and Medicaid days to be considered a resident of a NF.
  - Gaps in NF care of 15 days or less per discharge count toward the consecutive day requirement.
  - Any days that a member spends in an inpatient hospital setting, once already admitted to a NF, count toward the 100 day requirement.

Once a Medicaid recipient achieves the one-hundredth NF day (regardless of payer), the member is assigned to the NFLOC rate cell in the subsequent month and the plan would then be paid the higher rate associated with this population. NF residents that have been in a NF for 100 or more days immediately preceding that member's enrollment in the MyCare program will be classified into the NFLOC rate cell on the first day of enrollment. Enrollees who transition from a HCBS waiver to a NF will remain in the NFLOC rate cell; however, for population group stratification in the capitation rate development process and the MEMA adjustment, these individuals continue in the community waiver population group until the one-hundredth institutional day requirement is met.

There was insufficient data for Medicare Part C enrollees to determine the number of days since an individual was admitted to a NF. The rate cell definitions assume all MyCare-eligible members who are enrolled in a Medicare Part C plan and also admitted to a NF when enrolling in the MyCare program have incurred 8 consecutive days in a NF. The 8-day assumption was derived from the distribution of actual Medicare versus Medicaid days for Non-Part C enrollees who started and ended their 100 day threshold count during the base data year.

For the NFLOC rate cell, there is a single rate cell for each contracting region. The rates were developed using data from the following NFLOC population groups: institutional, community waiver 18 - 44, community waiver 45 - 64 and community waiver 65+.

August 2015 enrollment in MyCare Ohio will be used as a basis for the projected enrollment distribution by population group for calendar year 2016. The composite NFLOC rates reflect the anticipated mix of NFLOC members achieved through effective managed care activities.

#### **Transition Rules**

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

#### **(b) Methodology**

The structure, rationale, and payment methodology are discussed in (a) above.

### **C. MANAGED CARE EFFECT**

The blended nature of the NFLOC rate cell encourages MCOPs to manage the mix of the population towards lower cost settings. This is the basis for efficiencies in LTSS programs. This transition between settings (e.g. nursing facility to HCBS waiver services) is gradual in nature and is not an immediate transition. Most often, individuals that are in a nursing facility for a long period of time have lost their community supports and it becomes difficult to change the setting away from a nursing facility. Therefore, MCOPs will need to seek individuals that are newer to LTSS benefits and avoid or delay nursing facility placement. Because of this, we assumed gradual increases in HCBS percentages and decreases in nursing facility percentages. Our assumption for CY 2016 is that the average mix between HCBS and nursing facility will shift by 1% in favor of HCBS for the year.

### **D. NON-BENEFIT COST**

The non-benefit cost assumptions are discussed in Section I5. The non-benefit costs vary by population group and are appropriate for the MLTSS benefits and services.

### **E. EXPERIENCE AND ASSUMPTIONS**

Section I details the experience and assumptions employed for the MLTSS and non-MLTSS services included in the MyCare program.

## LIMITATIONS

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the CY 2016 actuarially sound rate range for the MyCare Ohio program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this letter will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for ODM by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman relied upon certain data and information provided by ODM and their vendors, primarily the historical claims and eligibility for MyCare eligible FFS members. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

The services provided by Milliman to ODM were performed under the signed contract agreement between Milliman and ODM dated June 11, 2015.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The actuaries preparing this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

## **ATTACHMENT 1: CERTIFIED RATES**

**Ohio Department of Medicaid  
MyCare Managed Care Program  
CY 2016 Opt-In Certified Rates**

<b>Population Group:</b>	<b>NFLOC Total</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 3,982.34	\$ 79.65	\$ 3,902.70
East Central	3,164.83	63.30	3,101.53
Northeast	3,750.43	75.01	3,675.42
Northeast Central	3,335.77	66.72	3,269.06
Northwest	3,454.20	69.08	3,385.12
Southwest	3,852.56	77.05	3,775.51
<u>West Central</u>	<u>3,170.93</u>	<u>63.42</u>	<u>3,107.51</u>
<b>Statewide Total</b>	<b>\$ 3,564.10</b>	<b>\$ 71.28</b>	<b>\$ 3,492.82</b>

<b>Population Group:</b>	<b>Community Well 18-44</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 427.43	\$ 8.55	\$ 418.88
East Central	258.67	5.17	253.50
Northeast	313.79	6.28	307.51
Northeast Central	220.61	4.41	216.20
Northwest	299.89	6.00	293.90
Southwest	274.57	5.49	269.08
<u>West Central</u>	<u>290.21</u>	<u>5.80</u>	<u>284.41</u>
<b>Statewide Total</b>	<b>\$ 302.33</b>	<b>\$ 6.05</b>	<b>\$ 296.28</b>

<b>Population Group:</b>	<b>Community Well 45-64</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 534.38	\$ 10.69	\$ 523.69
East Central	316.78	6.34	310.45
Northeast	386.77	7.74	379.04
Northeast Central	267.52	5.35	262.17
Northwest	369.90	7.40	362.50
Southwest	336.82	6.74	330.08
<u>West Central</u>	<u>356.98</u>	<u>7.14</u>	<u>349.84</u>
<b>Statewide Total</b>	<b>\$ 375.55</b>	<b>\$ 7.51</b>	<b>\$ 368.03</b>

<b>Population Group:</b>	<b>Community Well 65+</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 778.40	\$ 15.57	\$ 762.83
East Central	763.91	15.28	748.63
Northeast	633.00	12.66	620.34
Northeast Central	567.83	11.36	556.47
Northwest	576.72	11.53	565.18
Southwest	838.98	16.78	822.20
<u>West Central</u>	<u>827.54</u>	<u>16.55</u>	<u>810.99</u>
<b>Statewide Total</b>	<b>\$ 702.42</b>	<b>\$ 14.05</b>	<b>\$ 688.37</b>



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# July 2016 MyCare Ohio Provider Agreement Rate Amendment Summary

## Opt-Out Capitation Rates

July 1, 2016 through December 31, 2016

## Ohio Department of Medicaid

Prepared for:  
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**Attachment 1: Certified Rates**

## I. INTRODUCTION

This document is an abridged version of the capitation rate amendment entitled *July 2016 MyCare Capitation Rate Amendment Opt-Out Capitation Rates* and delivered to the Ohio Department of Medicaid (ODM) on June 3, 2016. For a complete version, please reference the specified document.

### Background

Milliman, Inc. (Milliman) has been retained by the Ohio Department of Medicaid (ODM) to provide actuarial and consulting services related to the development of capitation rates for its MyCare Ohio (MyCare) dual eligible managed care program. ODM, along with CMS and the MyCare Ohio plans (MCOPs), provides benefits for fully dual eligibles under the MyCare Ohio program within targeted geographic areas. This letter provides an amendment to the certified calendar year (CY) 2016 capitation rates for effective dates beginning July 1, 2016.

This report is an amendment to the documentation of the capitation rates developed for CY 2016. The previously certified capitation rates and the documentation of the development were published in the following correspondence provided by Milliman:

- *Calendar Year 2016 MyCare Ohio Capitation Rate Certification Opt-Out Capitation Rates* dated December 10, 2015 (Original)

We have updated the capitation rates provided in the Original certification to reflect Ohio's disability determination methodology conversion from the status of a 209(b) to a 1634 state (including the creation of a 1915(i) state plan option). Capitation rates have additionally been updated for Nursing Facility (NF) policy changes, a fee schedule increase for RN and LPN nursing services within the Home Health, PDN and Waiver categories of service, and an increase to care management costs for Waiver enrollees ages 60 and over. **Unless otherwise stated, the methodology and assumptions utilized are consistent with the capitation certification documentation included in the Original report.**

### General Information

The capitation rates provided with this certification are "actuarially sound" for purposes of 42 CFR 438.6(c), according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- The capitation rates meet the requirements of 42 CFR 438.6(c).

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Federal regulation 42 CFR §438.6(c).
- *2016 Medicaid Managed Care Rate Development Guide* published by CMS on September 23, 2015.
- Throughout this document, the term "actuarially sound" will be defined in ASOP 49:

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

## II. EXECUTIVE SUMMARY

### Summary of Methodology

The methodology used in developing the July 1, 2016 amendment to the certified CY 2016 capitation rates is outlined below.

#### ***Step 1: Base Experience***

We used the projected claims data underlying the CY 2016 MyCare capitation rates, as outlined in the Original certification, as base experience for developing the July 1, 2016 capitation rates. These projected claims costs are inclusive of all retrospective, prospective, trend, managed care efficiency, Opt-In versus Opt-Out selection and other claims cost adjustments made to the data as outlined in the Original certification.

#### ***Step 2: Adjustments for prospective program and policy changes***

The base experience is adjusted for known policy and program changes that are expected to be implemented in July through December 2016. This includes Ohio's conversion from the status of a 209(b) to a 1634 state including creation of a 1915(i) state plan option and the impact of discontinuing the spend down program. Adjustments have additionally been made to NF, Home Health, Private Duty Nursing and Waiver Nursing services fee schedules. Documentation of items requiring the calculation of adjustment factors is provided in this report. Adjustments are applied to the base experience data to reflect program changes not included in the Original certification. The resulting values establish the adjusted claim cost by population group and region for the contract period.

#### ***Step 3: Data smoothing for non-credible sub-populations***

Regional and age-based rating factors are developed consistent with the methodology in the Original certification as a data smoothing methodology for non-credible sub-populations.

#### ***Step 4: Inclusion of care management costs***

Care management is included in a separate service category as a single adjustment to costs. The care management costs represent the combination of two types of care management: AAA + plan management for waiver-eligible enrollees age 60 years and older, and other plan management for the remaining population groups. The care management costs for the AAA + plan management for waiver-eligible enrollees age 60 years and older have been updated to reflect data gathered from a recent care management survey completed by the MCOPs. Care management costs have not been revised for any population other than waiver-eligible enrollees ages 60 years and older.

#### ***Step 5: Incorporate non-claim items and adjustments***

The adjusted claim cost are modified to include the impact of certain non-benefit items, such as administrative expenses, risk margin, taxes and the 2% integrated care joint savings percentage for the Opt-In rates (corresponding to Demonstration Year 2). No changes were made to non-claim assumptions from the values included in the Original certification. The Consolidated Appropriations Act of 2016, signed on December 18, 2015, includes a moratorium of the ACA Health Insurer Provider Fee (HIPF) for 2017. As a result, 2016 MyCare-certified capitation rates are no longer expected to be adjusted for the HIPF.

#### ***Step 6: Development and issuance of actuarial certification***

An actuarial certification is included and signed by Jeremy D. Palmer, FSA, a Principal and Consulting Actuary in the Indianapolis office of Milliman, Inc. Mr. Palmer meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, in order to certify that the final rates meet the standards in 42 CFR §438.6(c).

The certified Opt-Out capitation rates by rate cell with and without the 2016 quality withhold are illustrated in Attachment 1. The rates are effective from July 1, 2016 through December 31, 2016.

### III. PROSPECTIVE DATA ADJUSTMENTS

#### Program Adjustments – July 2016

Adjustment factors for the July 1, 2016 MyCare rate amendment were developed for the following policy and program changes, known as of the date of this letter.

#### 209(b) to 1634 Conversion

Effective August 1, 2016, Ohio will convert their disability determination methodology from the status of a 209(b) to a 1634 state. Under the 1634 conversion, Ohio will extend Medicaid eligibility to all individuals who receive Supplemental Security Income (SSI). Individuals with SSI will be automatically enrolled in Medicaid. Additionally, Ohio will use the same definition for Medicaid eligibility coverage as the Social Security Administration. This will effectively increase the Federal Poverty Level income standard from 64% to 75%.

Additionally, on July 31, 2016, ODM will eliminate the existing Medicaid spend down program. A 1915(i) state plan option will create a special benefit program for adults 21 years of age and older with severe and persistent mental illness (SPMI) with income up to 225% of the federal poverty level that would not otherwise be eligible for Medicaid.

To ensure that impacted members have sufficient time to transition to other coverage sources, there will be a pause in redetermination. The following categories identify the intended eligibility status for MyCare potential enrollees. Ultimately, we anticipate no significant changes in MyCare enrollment distribution or acuity through December 2016.

#### **Current MyCare Dual Enrollees as of July 31, 2016**

Recurring spend downs – Enrollees remain in MyCare with MCOP paying prior spend down component until first redetermination on or after January 1, 2017 at which time continued MyCare eligibility is subject to 1634/1915(i) criteria.

All others – Enrollees remain in MyCare until first redetermination on or after January 1, 2017 at which time continued MyCare eligibility is subject to 1634/1915(i) criteria.

#### **Current Medicaid Dual Enrollees in MyCare Region but not MyCare as of July 31, 2016**

Non-recurring spend downs – Individuals who have met at least one month of spend down criteria in the past twelve months will become fully Medicaid eligible in fee-for-service (FFS) until at least December 31, 2016. Medicaid eligibility will be reviewed at first redetermination on or after January 1, 2017. Enrollees will shift to MyCare on January 1, 2018 if eligibility is retained during calendar year 2017 redetermination.

#### **In MyCare Region but Not Medicaid as of July 31, 2016**

Currently receiving SSI as of July 31, 2016 – Individuals become Medicaid FFS eligible on August 1, 2016 and transition to MyCare on August 1, 2017 subject to retaining 1634 status or meeting 1915(i) criteria at redetermination.

SSI application/approval on or after 8/1/2016 – Individuals become MyCare-eligible immediately upon meeting 1634 criteria.

1915(i) application on or after 8/1/2016 – Individuals become FFS-eligible following 1915(i) approval, transition to MyCare at first redetermination after January 1, 2017.

## Elimination of Spend Down

As mentioned under “Recurring spend downs” in the section above, elimination of spend down eligibility will temporarily result in additional cost to the MCOPs for certain Community Well MyCare enrollees. Specifically, recurring spend downs will become fully eligible under MyCare effective August 1, 2016 through their first redetermination on or after January 1, 2017. Thus, payment amounts that were previously the responsibility of the recurring spend down enrollees will no longer be collectable from the enrollees.

## 1915(i) - Specialized Recovery Services

Effective August 1, 2016, ODM is providing specialized recovery services (SRS) to individuals enrolled in Medicaid through the 1915(i) waiver. The planned delay in redetermination, along with timing needs for implementation of assessments and contracting of services, will significantly limit the number of individuals receiving SRS services under the 1915(i) waiver during the period of August 2016 through December 2016.

## Nursing Facility

### Per Diem Update

NF per diems will be rebased effective July 1, 2016. Along with the rebasing, ODM will be updating the resource utilization group (RUGs) methodology used to measure resident acuity. The methodology will be updated from RUGS III to RUGS IV to coincide with the calculation of new rate components during the rebasing process. Based upon detailed data provided by ODM, the rebasing and group update increase the original CY 2016 per diems for all regions except the Southwest region for which per diems are expected to decrease. The July 2016 rate amendment reflects the impact of the updated NF per diems on NF crossover, NF non-crossover and hospice room and board services.

### Peer Group Change

Along with the per diem update, Trumbull County will be reassigned from Peer Group 3 to Peer Group 2. The change in peer group in Trumbull County is expected to increase average per diems in the Northeast Central region.

### Reduced Reimbursement for Low Acuity Individuals

As of July 1, 2016, the gross daily rate paid for the lowest acuity individuals in Ohio's NFs (PA1 and PA2) will be reduced from \$130.00 per resident day to \$115.00 per resident day to more closely correspond with the expected cost of serving these individuals.

## Home Health, PDN and Waiver Nursing Services

Effective October 1, 2016, ODM will increase fees for G0154, T1000, T1002 and T1003 by an average 6% corresponding to approximately \$600,000 in additional MyCare expenditures through December 31, 2016.

## IV. CAPITATION RATE DEVELOPMENT

### Data Smoothing

Consistent with the data smoothing in the Original certification, regional and population group rating factors are developed and utilized as a data smoothing technique for low credibility region and population combinations. The smoothed rates form the cost basis for the final capitation rates.

### Care Management Costs

Care management is included as a separate service category as a single adjustment to costs. The care management costs represent the combination of two types of care management: AAA+ plan management for waiver-eligible enrollees age 60 years and older and other plan management for the remaining populations groups. As stated in the three way contract between ODM, CMS, and the MCOPs, the MCOPs are required to contract with AAAs to perform waiver service coordination for, at a minimum, individuals age 60 years and older. The AAA+ plan management costs for waiver-eligible enrollees age 60 years and older are increased by 9.0% over the Original certification to reflect data gathered from a care management survey completed by the MCOPs. Care management costs are not revised for any population other than waiver-eligible enrollees age 60 years and older.

### Administration and Other Non-Benefit Adjustments

Consistent with the Original certification, the adjusted claim cost are modified to include the impact of certain non-benefit items, such as administrative expenses, risk margin, taxes and the 2% integrated care joint savings percentage for the Opt-In rates (corresponding to Demonstration Year 2). No changes are made to non-claims assumptions from the percentages included in the Original certification.

## V. MEMBER ENROLLMENT MIX ADJUSTMENT (MEMA)

The MEMA provides an update of the rates to reflect the risk mix of enrollees in each MCOP compared to the mix that was used in the capitation rate development. Specifically, the MEMA addresses the relative risk/cost differences of the population groups that make up the NFLOC rate cell. The population groups within the NFLOC rate cell provide a proxy for assessment of risk differences among the MCOPs. The MEMA allocates additional revenue to plans covering a higher proportion of high risk individuals (Institutional and Community Waiver 18 - 44) and less revenue for plans covering a higher proportion of lower cost individuals (Community Waiver 45 - 64 and Community Waiver 65+). The MEMA is a budget-neutral adjustment which will be updated January and July of each year.

- April 2016 MyCare enrollment data will be used for the July 1, 2016 through December 31, 2016 MEMA development

## VI. LIMITATIONS AND DATA RELIANCE

The information contained in this report has been prepared for ODM to provide documentation of the development of the July 1, 2016 amendment to the certified Calendar Year 2016 MyCare Ohio capitation rates for the Opt-Out Population. The data and information presented may not be appropriate for any other purpose.

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

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

Milliman has relied upon certain data and information provided by ODM and the participating MCOPs in the development of the July 1, 2016 capitation rate amendment. Milliman has relied upon ODM and the MCOPs for the accuracy of the data and accept it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

The services provided by Milliman to ODM were performed under the signed contract agreement between Milliman and ODM dated June 11, 2015.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

## ATTACHMENT 1

**Ohio Department of Medicaid  
MyCare Managed Care Program  
July 2016 - December 2016 Opt-Out Certified Rates**

<b>Population Group:</b>	<b>NFLOC Total</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 4,538.71	\$ 90.77	\$ 4,447.94
East Central	3,943.61	78.87	3,864.73
Northeast	4,300.33	86.01	4,214.32
Northeast Central	4,608.88	92.18	4,516.70
Northwest	4,330.08	86.60	4,243.48
Southwest	4,555.87	91.12	4,464.75
West Central	3,568.21	71.36	3,496.85
<b>Statewide Total</b>	<b>\$ 4,225.29</b>	<b>\$ 84.51</b>	<b>\$ 4,140.78</b>

<b>Population Group:</b>	<b>Community Well 18-44</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 594.93	\$ 11.90	\$ 583.04
East Central	371.06	7.42	363.64
Northeast	445.09	8.90	436.18
Northeast Central	310.10	6.20	303.90
Northwest	419.99	8.40	411.59
Southwest	386.79	7.74	379.05
West Central	407.25	8.14	399.10
<b>Statewide Total</b>	<b>\$ 427.72</b>	<b>\$ 8.55</b>	<b>\$ 419.16</b>

<b>Population Group:</b>	<b>Community Well 45-64</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 705.15	\$ 14.10	\$ 691.05
East Central	435.21	8.70	426.51
Northeast	523.68	10.47	513.21
Northeast Central	361.54	7.23	354.31
Northwest	494.16	9.88	484.28
Southwest	453.82	9.08	444.75
West Central	478.49	9.57	468.92
<b>Statewide Total</b>	<b>\$ 500.69</b>	<b>\$ 10.01</b>	<b>\$ 490.68</b>

<b>Population Group:</b>	<b>Community Well 65+</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 1,025.86	\$ 20.52	\$ 1,005.34
East Central	1,091.23	21.82	1,069.40
Northeast	849.90	17.00	832.91
Northeast Central	898.85	17.98	880.87
Northwest	797.66	15.95	781.71
Southwest	1,108.07	22.16	1,085.91
West Central	1,146.54	22.93	1,123.61
<b>Statewide Total</b>	<b>\$ 981.49</b>	<b>\$ 19.63</b>	<b>\$ 961.86</b>



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# Calendar Year 2016 MyCare Ohio Provider Agreement Rate Summary

Opt-Out Capitation Rates

January 1, 2016 through December 31, 2016

Ohio Department of Medicaid

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**ATTACHMENT 1: CERTIFIED RATES**

## INTRODUCTION

This document is an abridged version of the capitation rate certification entitled *Calendar Year 2016 Ohio Capitation Rate Certification Opt-Out Capitation Rates January 1, 2016 through December 31, 2016* and delivered to the Ohio Department of Medicaid (ODM) on December 10, 2015. For a complete version, please reference the specified document.

## BACKGROUND

Milliman, Inc. (Milliman) has been retained by the (ODM) to provide actuarial and consulting services related to the development of the calendar year 2016 (demonstration year 2) capitation rates for MyCare Ohio. MyCare Ohio is Ohio's managed care program for the dual eligible (Medicare-Medicaid) population. Eligible individuals are required to either receive both Medicare and Medicaid services (Opt-In) or Medicaid services only (Opt-Out) through the managed care plan. Enrollees who select to Opt-In become Integrated Care Delivery System (ICDS) participants in the Dual Demonstration program.

This letter provides the development of the actuarially sound calendar year 2016 capitation rates for Opt-Out individuals. Unless otherwise specified, all references to "rates" or "capitation rates" throughout this document refer to the Medicaid-specific component of the MyCare Ohio capitation rates.

To facilitate review, this document has been organized in the same manner as the 2016 Managed Care Rate Setting Consultation Guide (2016 guide), released by CMS in September 2015.

## CERTIFIED CAPITATION RATES

The certified Opt-Out capitation rates by rate cell with and without the 2016 quality withhold are illustrated in Attachment 1. The rates are effective from January 1, 2016 through December 31, 2016.

## SECTION I. MEDICAID MANAGED CARE RATES

### 1. GENERAL INFORMATION

This section provides information listed under the General Information section of the 2016 Managed Care Rate Setting Consultation Guide (2016 guide), Section I.

The capitation rates provided with this certification are “actuarially sound” for purposes of 42 CFR 438.6(c), according to the following criteria:

- The capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- The capitation rates meet the requirements of 42 CFR 438.6(c).

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date
- Federal regulation 42 CFR §438.6(c).
- *2016 Medicaid Managed Care Rate Development Guide* published by CMS on September 23, 2015.
- Throughout this document, the term “actuarially sound” will be defined consistent with ASOP 49:

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

### A. ANNUAL BASIS

The actuarial certification contained in this report is effective for the capitation rates for the one year rate period from January 1, 2016 through December 31, 2016.

### B. DOCUMENTATION

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

### C. INDEX

The index to this rate certification is the table of contents, found immediately after the title page. The index includes section numbers and related page numbers. Sections not relevant to this certification continue to be provided, with an explanation of why they are not applicable.

## D. REQUIRED ELEMENTS

### i. Actuarial certification

The actuarial certification was signed by Jeremy D. Palmer, FSA, MAAA. Mr. Palmer meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certify that the final rates meet the standards in 42 CFR §438.6(c).

### ii. Certified rates

The certified Opt-Out capitation rates by rate cell with and without the quality withhold are illustrated in Attachment 1. These rates represent the contracted capitation rates prior to risk adjustment.

### iii. Capitation rate ranges for each rate cell

### iv. Program information

#### (a) Managed care program

ODM, along with CMS and the MyCare Ohio plans (MCOPs), provides benefits for fully dual eligibles under the MyCare Ohio program within targeted geographic areas. This letter provides the documentation and certification of the calendar year 2016 capitation rates for the Medicaid component of the MyCare Ohio program for Opt-Out individuals.

MyCare Ohio began a phased-in schedule of enrollment starting in May 2014 among 5 full-risk managed care plans in 7 regions. Demonstration Year 1 was comprised of the partial year 2014 and the complete calendar year 2015 time periods.

Separate rates were developed for Opt-In versus Opt-Out enrollees. The rates vary based upon enrollee selection assumptions and the 2% integrated care joint savings percentage for the Opt-In population for Demonstration Year 2 as identified in the three-way contract between ODM, CMS, and the MCOPs.

The services provided under this contract include complete physical and behavioral health, and long-term services and supports. The program pays secondary to Medicare for Medicare covered services.

#### (b) Rating period

This actuarial certification is effective for the one year rating period January 1, 2016 through December 31, 2016.

#### (c) Covered populations

The MyCare Ohio eligible population includes all “full benefit” Medicare and Medicaid enrollees age 18 and over within the selected MyCare demonstration counties. The following describes the populations ***not*** eligible to participate in the MyCare program:

- Partial Medicare Eligibility
- Delayed and Other Spend-down
- PACE
- Intellectual Disabilities and Other Developmental Disabilities (IDD)
- Receives Third-Party Liability (TPL) Benefits
- CMS Independence at Home (IAH) Demonstration
- Employee Union Coverage and/or Retiree Drug Subsidy
- Incarcerated Recipients
- Other Exclusion Populations

#### **(d) Eligibility criteria**

Enrollment in MyCare is mandatory for eligible individuals. Eligible individuals are required to either receive both Medicare and Medicaid services (Opt-In) or Medicaid services only (Opt-Out) through the managed care plan. Enrollment occurs on a passive basis such that eligible members must specify their decision to Opt-Out. Enrollees who remain Opt-In become Integrated Care Delivery System (ICDS) participants in the Dual Demonstration program.

#### **(e) Covered services**

Covered services are split into three service groupings: crossover services, non-crossover services, and waiver services based upon category of service logic.

## **2. DATA**

### **A. DESCRIPTION OF THE DATA**

#### **i. Description of the data**

##### **(a) Types of data**

The following experience served as the primary data sources for the calendar year 2016 MyCare Ohio capitation rate development:

- Fee for service (FFS) data for the MyCare eligible population for May 1, 2013 through April 30, 2014 (base data year)
- Calendar year (CY) 2014 and YTD June 2015 MCOP cost reports (financial summaries) – reference only

##### **(b) Age of the data**

The data used to develop the capitation rates is primarily from May 1, 2013 through April 30, 2014. The data is reported with claims run-out through August 31, 2015. The entire base data year is prior to implementation of managed care for the MyCare population.

##### **(c) Data sources**

The historical FFS data used as a primary data source for this certification was provided by ODM through the monthly vendor files. The vendor files are developed and maintained by Hewlett Packard (HP), ODM's fiscal agent.

The MCOP financial summaries were submitted to ODM and Milliman by each plan. The financial summaries were used as reference only to inform our actuarial judgment of the assumptions used to adjust and project the capitation rates.

##### **(d) Sub-capitation**

The FFS base data does not include sub-capitation amounts.

#### **ii. Availability and quality of the data**

##### **(a) Steps taken to validate the data**

The majority of the data used in this certification is fee-for-service data provided by the fiscal agent. The fiscal agent, HP, is primarily responsible for ensuring the accuracy and completeness of the fee-for-service claims data. ODM and Milliman monitor claims data monthly to identify inconsistencies in the data and work with HP to validate the claims and enrollment information.

Additionally, ODM and Milliman collect quarterly cost reports (financial summaries) from the MCOPs. These reports reflect the MCOP's estimate of membership, incurred claims, administrative costs, and revenue by region and rate cell. The base FFS data was compared to the cost reports where applicable for consistency.

### **(b) Actuary's assessment**

As required by Actuarial Standard of Practice No. 23, Data Quality, we disclose that we have relied upon certain data and information provided by ODM and their vendors, primarily the MCOPs and ODM's fiscal agent. The certification is dependent upon this reliance.

The FFS data represents the most appropriate data to be used for developing the actuarially sound capitation rates for the CY 2016 MyCare program. The MCOP cost reports are believed to be useful for reference purposes only as opposed to explicit base data. The cost reports contain indications of MCOP costs and are used to inform assumptions used to adjust the FFS data.

The MCOP encounter data is not of sufficient quantity or quality to be relied upon for the development of actuarially sound capitation rates.

### **(c) Data concerns**

We have not identified any material concerns with the quality or availability of the FFS data. The only concern is that it requires additional assumptions and adjustments to reflect the coverage and service delivery of the MyCare managed care program.

### **iii. Use of encounter and fee-for-service data**

We confirm that FFS claims and enrollment were used as the primary data source for this certification. The base data used reflects the historical experience and covered services most closely aligned with the MyCare program.

### **iv. Use of managed care encounter data**

Encounter data was not used for this certification. The MCOP encounter data is not of sufficient quantity or quality to be relied upon for the development of actuarially sound capitation rates. The program began in May 2014 and the encounter data has not been validated. While validation efforts continue, there remain numerous reporting issues for many MCOPs that have not been resolved.

## **B. DATA ADJUSTMENTS**

Capitation rates were developed from historical FFS data, incurred from May 1, 2013 to April 30, 2014, and paid through August 31, 2015. The primary base data year adjustments include completion adjustments, reimbursement adjustments, and other program adjustments.

### **i. Credibility adjustment**

The MyCare eligible populations, in aggregate, were considered fully credible. No adjustments were made for credibility in the aggregate; however we did implement data smoothing among population groups and regions as discussed in a later section of this report.

### **ii. Completion adjustment**

The base data year includes 12 months of incurred claims, with 16 additional months of claim payments. To develop the completion factors, we used an additional 16 months of earlier historical experience. This allowed us to analyze payment completion patterns in the earlier experience and apply it to the base year data.

### iii. Errors found in the data

No material errors were found in the data.

### iv. Program change adjustments

The base data year represents a historical time period from which projections were developed. We reviewed prior rate setting documentation and other materials from ODM to identify program changes that were implemented during the base data period. To the extent the program adjustments were estimated to have a material impact on MCOP service or administrative costs, an adjustment was considered for the calendar year 2016 rate development process. Adjustments were made to the portion of the base data prior to the implementation of each program change in order to ensure the entire base period was on a consistent basis. Relevant historical program changes are discussed below. Program changes have been grouped into three categories: nursing facility (NF), HCBS waivers, and other medical, as summarized below. Other base data year changes are also described.

#### ***Nursing Facility***

- ***NF Rate Changes – Various Effective Dates***

The NF adjustment factors include the impact of the semi-annual per diem case mix updates through January 2014 as well as the additional policy changes listed below. All NF analyses (policy changes and trend analysis) were performed separately for gross claims payments versus patient liability.

- NF Change to Peer Group for Stark and Mahoning Counties – October 1, 2013
- Update to base rate components inclusive of the impact of unbundling of select services – January 1, 2014

#### ***HCBS Waiver Services***

- ***Ohio Department of Aging (ODA) Waiver Services Fee Increase – July 1, 2013***

Effective July 1, 2013, ODM increased the reimbursement for certain Ohio Department of Aging (ODA) waiver services.

- ***Waiver Consolidation (MyCare Members Only) – March 1, 2014***

The implementation of MyCare included the consolidation of existing waiver programs into the MyCare Waiver. Prior to MyCare implementation, members were assessed for needs and assigned a specific waiver program. MyCare now provides eligibility for all services under the MyCare waiver, instead of only the services specific to the waiver program a member would have been assigned to previously.

- ***Elimination of Cost Cap from ODA Waivers (MyCare Members Only) – March 1, 2014***

Prior to elimination of the cost cap, to be eligible for PASSPORT and Choices waivers, projected waiver costs must be no greater than 60% of the cost of institutionalization. Under MyCare, this requirement has been removed.

#### ***Other Medical Services***

- ***Medicare Coinsurance Decrease for Behavioral Health Treatment Services***

Medicare recipients are responsible for coinsurance payments for behavioral health treatment services, which for dual eligibles is covered by Medicaid. Prior to 2010, Medicare coinsurance for behavioral health services was 50%. Starting in 2010, the coinsurance level began to grade-down to 20%, which is consistent with typical Part B cost sharing. Ohio Medicaid provides coverage for the recipient coinsurance amounts for these services. Cost adjustments were calculated for the behavioral health and some physician crossover services.

- **Outpatient Unlisted Codes**

Effective January 1, 2014, ODM adopted a percentage of cost payment structure instead of reimbursing hospitals for certain outpatient services at 100% of cost.

- **Inpatient Hospital APR-DRG Reimbursement Adjustments**

Beginning on July 1, 2013, ODM rebased its hospital base rates using All Patients Refined Diagnosis Related Groups (APR DRG). If a hospital is in a Metropolitan Statistical Area (MSA) peer group and is not a Medicare designated critical access hospital, then the hospital's APR DRG payments are subject to a two-sided risk corridor relative to the prior DRG prospective payment system in effect prior to July 1, 2013. This risk corridor percentage has been increased according to the following schedule: 3% for the 12 month period beginning July 1, 2013; 5% for the 12 month period beginning July 1, 2014; and 8% for the 12 month period beginning July 1, 2015.

- **Part B Crossover Payment Policy Change to Medicaid Maximum Payment**

For certain Part B services, ODM revised reimbursement to be the difference between the Medicaid allowed amount and the Medicare paid amount for those Part B services. The Medicaid maximum payment change was effective in January 1, 2014, with the exception of ambulatory surgery centers, dialysis clinics, and physician services. Prior to the Medicaid max payment methodology, ODM reimbursed up to the Medicare allowed amounts for all Part B services.

#### **Other Base Year Adjustments**

- **Third-Party Liability**

The MyCare program eligibility requirements exclude individuals with third-party insurance coverage. This criteria eliminates the vast majority of third-party liability. Any remaining third-party liability was considered immaterial.

- **Disproportionate Share Hospital (DSH) Payments**

The base data year FFS claims do not include DSH payments. Therefore, no adjustment was necessary to exclude these payments.

- **Graduate Medical Education (GME) Payments**

The base data year FFS claims include payments secondary to Medicare for crossover services and primary for non-Medicare covered inpatient claims. The inpatient fee schedule includes GME payments as part of the prospective payment rate, and were therefore included in the data as part of the Medicaid payment. For crossover claims, GME will be included only to the extent (or proportion) that the Medicaid allowed is included in the payment.

- **Patient Liability**

Members receiving LTSS may be required to contribute income towards their long-term care costs. This can be applied to both nursing facility and HCBS services. In general, the providers are collecting the patient liability directly and therefore these payments are removed from the calculation of the capitation rates. The exception to this is for legacy PASSPORT and Choices waiver individuals where the ODM collects the patient liability amounts. For these 2 cases, the capitation rates were not reduced by patient liability amounts.

- **Blend of Traditional Medicare and Medicare Part C**

The historical base data year comprises FFS claims and enrollment from individuals that were either enrolled in traditional Medicare or Medicare Part C for their Medicare benefits. We considered a straight blend of this experience in the base data year, but for crossover services it was determined that traditional Medicare experience was the most appropriate base cost. This results from the variation in benefit design observed from Medicare Part C plans and the resulting Medicaid payment.

The adjusted base data year includes a member month weighted average of the Part C and Non-Part C experience for non-crossover and waiver services, and only Non-Part C for crossover services.

We applied a selection adjustment specific to the crossover services to reflect that Part C individuals were not included in the base data year because of our blending methodology.

- **Fraud and Abuse Recoveries**

The base data year FFS claims already reflect the reduction for any amounts that have been identified and re-adjudicated or denied due to fraudulent activities. Additionally, we included a reduction of 0.25% to all services to reflect that there are additional recoveries not reprocessed through the claim system.

### 3. PROJECTED BENEFIT COST AND TRENDS

#### A. DEVELOPMENT OF PROJECTED BENEFIT COSTS

##### i. Description of the data, assumptions, and methodologies

The adjusted FFS base data year described in the previous section reflects benefits and program requirements as of the end of the data period (April 30, 2014). The following adjustments were applied to reflect the benefits and program requirements in CY 2016, including adjustments to reflect a managed care environment and trend to the midpoint of the effective period of the capitation rates.

##### (a) Prospective program changes

- **Nursing Facility**

Aside from case mix changes, there have been no NF benefit or fee changes subsequent to January 2014. We have reflected the annualized impact of case mix changes in the trend assumptions so no prospective program adjustment is needed. As previously stated, the impact of case mix through January 2014 is included in the retrospective NF program adjustment.

- **Dental Benefits and Fee Changes – January 1, 2016**

ODM has approved policy changes regarding the dental benefit and fee schedule, effective January 1, 2016.

- *Periodontal Scaling and Root Planning* - Dental benefits will be extended for periodontal scaling and root planning services.
- *Dental Fee Schedule Changes* - The dental fee schedule will increase for specific dental codes (primarily extractions and denture repair), but these increases do not apply to dental services provided in an FQHC.
- *Fee Schedule Increase for Rural Counties* - ODM will implement a 5% rural fee schedule differential across all CDT codes, determined by the county in which the provider is located.

- ***Nurse & Aide Service Rate Modernization – July 1, 2015***

Effective July 1, 2015, ODM instituted new services and reimbursement changes for nurse and aide services. These reimbursement and service changes impact both state plan home health / private duty nursing services and multiple waiver services.

- ***Home Health Aide Services– January 1, 2016***

The reimbursement for home health aide services paid under code G0156, other than those provided by an independent provider, were increased by 5% over the rate in effect on October 1, 2015

- ***Non-Agency Home Health Nurse/Aide Overtime – January 1, 2016***

ODM received federal guidance requiring the payment of overtime by non-agency home health providers. This adjustment was calculated by reviewing claims on a weekly basis for the impacted procedures and providers. The list of impacted procedures and providers was provided by ODM. The overtime payment was only applied to the wage component of each procedure fee.

- ***Increase Medicaid Physician Rates – January 1, 2016***

Effective on January 1, 2016, ODM is increasing the reimbursement to physicians for certain procedures. The adjustment only impacts certain procedures and the amount by code varies. The impact of these reimbursement changes was calculated net of the impact of the change to the Medicaid maximum payment methodology.

- ***Reimbursement Refinements for Radiology Services – January 1, 2014***

Effective January 1, 2014, ODM modified its reimbursement policy for radiology services that occur when more than one radiology procedure is performed by the same provider or provider group for an individual patient on the same date. The adjustment for the modifications made to the reimbursement of radiology services is captured in the Radiology/Pathology/Laboratory service category of the repricing of physician services.

- ***Physician Crossover Policy Change to Medicaid Maximum Payment – January 1, 2016***

The crossover reimbursement for physician services reflected in the base data includes all Medicare allowed amounts not paid by Medicare. Effective January 1, 2016, ODM will make a program change to limit reimbursement to the Medicaid maximum amount rather than providing payment up to the Medicare allowed amount. Other Medicare Part B services transitioned to the Medicaid maximum payment methodology on January 1, 2014. Services associated with dialysis clinics and ambulatory surgical centers will continue to be exempt from Medicaid maximum policy changes.

The following crossover service categories were affected:

- Physician Services
- FQHC / RHC
- Optometric Services
- Radiology / Pathology / Laboratory
- Other Non-Waiver Services

- **5% Outpatient Hospital Reimbursement Reduction – January 1, 2016**

Effective January 1, 2016, outpatient hospital facility reimbursement for all providers, with the exception of children’s hospitals, will be reduced by 5%. Ambulatory surgical centers are not impacted by this reimbursement change. The impact of this reimbursement change was valued in coordination with the ongoing impact of the Medicaid maximum payment methodology.

- **DRG-Exempt Reimbursement Adjustments – October 1, 2014**

Effective October 1, 2014, DRG-exempt hospitals were reimbursed for hospital services at 90% of the calculated cost-to-charge ratio for freestanding rehabilitation hospitals and freestanding long-term care hospitals. Prior to this date, these facilities were reimbursed at 100% of cost.

- **Hospital-Administered Drugs – January 1, 2016**

As of January 1, 2016, when a hospital independently bills for prescription drugs, reimbursement will be based on ODM’s fee schedule. To the extent the drug is not on the fee schedule, the drug will continue to be reimbursed at 60% of cost. The hospital-administered drug adjustment was calculated subject to the ongoing impact of Medicaid maximum payment methodology.

## **(b) Managed care efficiency adjustments**

Managed care adjustments primarily reflect the expected mix impact related to projected enrollment shifts between population group categories.

In addition to the mix impact, home health/private duty nursing in the Central/Southeast region was targeted based on significantly higher utilization compared to other regions. This pattern was also observed in the Aged, Blind, or Disabled (ABD) non-dual population before it was transitioned to mandatory managed care.

The experience from ABD suggests that the managed care program would be able to reduce the amount of this service as compared to FFS in the Central/Southeast region. We applied an adjustment specific to this region to reflect the expected reduction.

With respect to population enrollment shifts, we assumed that 1% of NF enrollment will shift in favor of HCBS for 2016. We further assumed that cost effective utilization improvements for waiver services (in a managed care environment compared to a FFS environment) would offset the influx of more costly enrollees into waivers due to the transition from NF.

## **(c) Opt-Out selection adjustments**

We calculated adjustments to reflect the selection risk corresponding to the option of Opt-In versus Opt-Out for individuals in the MyCare program. These selection adjustments vary by population group and service category.

## **(d) Data smoothing**

Regional and population group rating factors were developed and utilized as a data smoothing technique for low credibility region and population combinations. For example, regional and population group cost relativities were developed from the combined data for all Community Waiver populations. The regional and population group cost relativities were utilized for the development of final Community Waiver 18 - 44, Community Waiver 45 – 64, and Community Waiver 65+ PMPM claims cost. This same process was separately applied to the Community Well non-aged populations and regions.

## ii. Material changes to the data, assumptions, and methodologies

The capitation rates calculated for CY 2016 reflect a complete rebasing of claims and assumptions compared to the CY 2015 capitation rates.

- FFS data remains the basis for the rate development, but the data period has been moved forward from 5/1/2009 - 4/30/2011 to 5/1/2013 - 4/30/2014.
- In the prior methodology, experience for individuals enrolled in Medicare Part C was excluded. The CY 2016 methodology fully reflects Medicare Part C claims and enrollment experience for non-crossover and waiver services and includes a selection adjustment to recognize the exclusion of Medicare Part C enrollee experience from base data for crossover services. Additional discussion of the blending of Non-Part C and Part C data is provided in Section 2.B.iv.
- The development of certain adjustment factors, for retrospective program and policy changes, has been revised to include analysis of actual claims experience subsequent to the program or policy changes.
- CY 2014 and YTD June 2015 MCOP cost reports (financial summaries) were reviewed for validation of updated assumptions.
- The impact of prospective program adjustments has been analyzed in coordination with the existing Medicaid maximum reimbursement logic where appropriate.
- All completion, trend, selection and managed care assumptions have been updated based upon analysis of the more recent FFS data.
- Assumptions dependent upon the MyCare enrollment distribution between Opt-In versus Opt-Out and between population groups have been updated with actual MyCare enrollment data.
- Administrative cost percentages have been modified to keep CY 2016 administrative costs consistent with CY 2015 on a PMPM basis for the combined MyCare Opt-In and Opt-Out rates.

## B. PROJECTED BENEFIT COST TRENDS

### i. Description of the data, assumptions, and methodologies

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (May 1, 2013 to April 30, 2014) to the CY 2016 rating period.

Total benefit cost trends were developed on a PMPM basis consistent with prior years' certifications. The move to a utilization and unit cost approach is expected once encounter data can be used as the basis for the data. While the trends are illustrated on a PMPM basis, they reflect primarily utilization and mix/intensity of services. Unit cost trend, with the exception of the impact of case mix on NF per diem rates, is primarily handled through the program changes to reflect expected 2016 reimbursement.

#### (a) Data

The primary data source used in the development of the historical FFS trends includes 28 months of incurred claims beginning January 2012 and ending April 2014.

Data sources that were additionally referenced include:

- *National Health Expenditure (NHE) projections* developed by the CMS office of the actuary, specifically those related to Medicaid.
- Public capitation rate reports from other state programs. We collect and maintain certifications from other Milliman offices as well as states that make their documents publicly available.

## **(b) Methodology**

The FFS data was summarized by population group, service category, and service month. We normalized the experience for material program adjustments to reflect a consistent reimbursement and covered benefit structure. The resulting historical trends were summarized as a data point in our process.

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We also referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in this specific population, and shifting population mix. The annual trend assumptions include the limited impact of 2016 as a leap year. The impact is minimized by the fact that the trends are applied for 32 months which equates to an approximate 0.1% annualized impact.

### **ii. Benefit cost trend components**

Total benefit cost trends were developed on a PMPM basis consistent with prior years certifications. The move to a utilization and unit cost approach is expected once encounter data can be used as the basis for the data. While the trends are illustrated on a PMPM basis, they reflect primarily utilization and mix/intensity of services. Unit cost trend is generally handled through the program changes to reflect expected 2016 reimbursement.

### **iii. Variation**

The trends have been developed by service category. Trend variations between service categories reflect variation in the underlying historical experience and our actuarial judgment.

### **iv. Material adjustments**

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We also referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in this specific population, and shifting population mix.

We made adjustments to the trends derived from historical experience in cases where the resulting trends did not appear reasonably sustainable, or were not within consensus parameters derived from other sources.

### **v. Any other adjustments**

#### **(a) Impact of managed care**

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost. The capitation rates have an explicit adjustment for the managed care adjustments.

#### **(b) Trend changes other than utilization and unit cost**

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

## **C. IN LIEU OF SERVICES**

The projected benefit costs do not include costs for in lieu of services.

## **D. RETROSPECTIVE ELIGIBILITY PERIODS**

### **i. Health plan responsibility**

Under the MyCare contract, the health plans are not responsible for retrospective eligibility periods. Services during retrospective eligibility periods are provided on a fee-for-service basis.

## ii. Base data treatment

The historical FFS data includes all eligibility spans for a MyCare eligible individual, including retrospective eligibility. We worked with ODM in an attempt to identify such eligibility spans but there was not an appropriate identification. We discussed the implications with ODM and determined that we could not make an explicit adjustment for this program item. We believe that through review of the emerging experience of the MCOPs that our base claim cost is appropriate without a material adjustment for this item.

## iii. Enrollment treatment

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

# 4. PASS-THROUGH PAYMENTS

This section is not applicable because there are no pass-through payments for the MyCare program. We assume that incentive payments, as listed in this section of the CMS rate consultation guide as a pass-through, were intended to indicate payments to medical or LTSS service providers and not incentive payments to the MCOP. Incentive payments available for MCOPs are documented in Section 7.

# 5. PROJECTED NON-BENEFIT COSTS

## A. DATA, ASSUMPTIONS AND METHODOLOGIES

### i. Description of the data, assumptions, and methodologies

#### (a) Data

The primary data sources used in the development of the CY 2016 non-benefit costs are listed below:

- Review of the cost reports (financial summaries) from the MCOPs covered under the MyCare contract.
- Assumptions employed by the previous actuary.
- Publicly available information for other state Medicaid programs.
- Actuarial judgment.

#### (b) Assumptions and methodology

We summarized the historical cost report data against the assumptions employed in the current capitation rates. There appeared to be general consistency when looking at the care management and overall administrative costs reported by the MCOPs. As such, we established overall administrative costs that were similar on a composite PMPM equivalent basis to the current year assumptions.

### ii. Material changes

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

## B. NON-BENEFIT COSTS, BY COST CATEGORY

### i. Administrative costs

At the present time, the administrative cost has not been developed from the ground up (based on individual components). The components may appropriately interact, and ODM does not wish to dictate to the plans how these may be allocated.

The CY 2016 administrative cost allowance for MyCare is determined as a percentage of the capitation rates net of taxes and assessments. Administrative cost percentages have been modified to keep CY 2016 administrative costs consistent with CY 2015 on a PMPM basis for the combined MyCare Opt-In and Opt-Out rates.

### ii. Care coordination and care management

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

Plans are required to contract with Area Agencies on Aging (AAAs) to perform care management for members who are 60 years or older and on a waiver. The original rate component for AAA care management was developed under the previous certification and based on AAA cost report data. In addition to care management provided by AAAs, there is a plan component of care management included for each rate cell. The plan component for those 60 years or older is incorporated in the AAA rate.

One change from the previous year's actuarial certification was the removal of the SPMI health home component of the care management payment. These costs were explicitly added to the capitation rates in CY 2015 because the cost was not included in the base period experience. With the rebasing of data for CY 2016, these costs are included in our base data year. As such, we removed the explicit addition of this cost in the capitation rate development. We have assumed that all claims cost associated with health home services will be redirected on a budget neutral basis as the health home program phases out.

### iii. Provision for margin

The risk margin included in the CY 2016 MyCare capitation rates is 2.0% for each population group consistent with the margin assumption included in the CY 2015 rates.

### iv. Taxes, fee, and assessments

MCOPs are subject to a sales and use tax that varies by county. We obtained the tax rates by county from the State of Ohio website ([http://www.tax.ohio.gov/sales\\_and\\_use.aspx](http://www.tax.ohio.gov/sales_and_use.aspx)) and weighted the county-level tax amounts by August 2015 enrollment by county. MCOPs are also required to pay 1% of revenue for the Health Insuring Corporation (HIC) tax. The following table illustrates the sales and use tax and HIC tax by MyCare region.

### v. Other material non-benefit costs

Expected savings from the integration of Medicare and Medicaid services for the Opt-In population are explicitly reflected as the 2% integrated care joint savings percentage referenced in the non-benefit and expenses adjustment section of the methodology letter.

## C. PMPM VERSUS PERCENTAGE

The non-benefit cost for MyCare was developed as a percentage of the capitation rate for administrative costs and risk margin. Care management costs were developed on a PMPM basis.

## D. HEALTH INSURER FEE

### i. Whether the fee is incorporated in the rates

We have not included the health insurer fee into the capitation rates. We will restate the capitation rates at the time that the actual tax amounts are known and submit an amended capitation rate certification.

### ii. Fee year or data year

The amount to be added to the capitation rates will be based on a data year basis. For example, the 2016 capitation rates will be restated when the 2017 tax is due.

### iii. Determination of fee impact to rates

The amount to be added to the 2016 rates will be based on the actual fee for 2017 and actual tax impact of reimbursement of the fee.

### iv. Description of process

The calculation of the fee for each MCOP subject to the HIF will be based on the final Form 8963 premium amounts reported by the insurer, aggregate HIF premium base, final IRS invoices provided to the MCOPs subject to the HIF, Form 8963 premium amounts attributable to ODM, data year HIF tax percentage, and adjustments for premium revenue based on benefits described in 26 CFR 57.2(h)(2)(ix) such as nursing home and home health care. Final fee amounts are adjusted for applicable fees and taxes that are applied to ODM capitation rate revenue (documented in the non-benefit expense section of this report). The 2016 capitation rates will be amended based on the 2017 HIF attributable to the 2016 data year. We anticipate amending the rates in the last quarter of calendar year 2017.

### v. Excluded benefits

The long term care benefit costs associated with MyCare are extensive. This will significantly limit the amount of the MyCare revenue that is subject to the fee.

## 6. RATE RANGE DEVELOPMENT

This section is not applicable because rate ranges were not established for the MyCare program.

## 7. RISK MITIGATION AND RELATED CONTRACTUAL PROVISIONS

### A. DESCRIPTION OF RISK MITIGATION

The MyCare rates have been developed as full risk rates. The MCOPs assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract. The regional NFLOC rates will be prospectively adjusted by MCOP to reflect mix differences in the enrolling population between nursing facility and HCBS services. This adjustment will be made to the rates prospectively. No additional risk adjustment is planned for this population in CY 2016.

## **B. RISK ADJUSTMENT MODEL AND METHODOLOGY**

### **i. Risk adjustment model**

For the prospective member mix, we will continue to employ the Member Enrollment Mix Adjustment (MEMA). This methodology adjusts the NFLOC capitation rates based on a MCOPs mix of nursing facility and HCBS membership.

### **ii. Data and adjustments**

- The MEMA is a budget-neutral adjustment which will be updated January and July of each year.
- October 2015 MyCare enrollment data will be used for the January 1, 2016 through June 30, 2016 MEMA development
- April 2016 MyCare enrollment data will be used for the July 1, 2016 through December 31, 2016 MEMA development

### **iii. Changes from the prior year**

Aside from timing, there are no methodology changes from the prior year.

### **iv. Frequency**

MEMA factors will be calculated each six month period. The prospective adjustment will be made once prior to the beginning of the contract period and once in July 2016.

### **v. How the risk scores will be used to adjust the capitation rates**

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

### **vi. An attestation that the risk adjustment is cost neutral**

The MyCare MEMA is designed to be cost neutral. Relative adjustments will be normalized to result in an aggregate adjustment of 1.000 for each region, across all plans.

## **C. ADDRESS COST NEUTRALITY**

This section is not applicable to MyCare Ohio as the MEMA adjustment is designed to be budget neutral.

## **D. OTHER RISK SHARING ARRANGEMENTS**

No other risk sharing arrangements are proposed for the 2016 capitation rates.

## **E. MEDICAL LOSS RATIO**

### **i. Description**

The MCOPs have a target MLR of eighty-five percent (85%). The MLR calculation for the Opt-Out shall be determined consistent with Opt-In as defined in the 3-way contract.

## ii. Financial consequences

The MCOPs have a target MLR of eighty-five percent (85%). If an MCOP has an MLR between eighty-five percent (85%) and ninety percent (90%) of the joint Medicare and Medicaid payment to the MCOP, ODM and CMS may require a corrective action plan.

If an MCOP has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment, the MCOP must remit the amount by which the eighty-five percent (85%) threshold exceeds the MCOPs 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.

## F. REINSURANCE REQUIREMENTS AND EFFECT ON CAPITATION RATES

MyCare MCOPs are required to maintain minimum reinsurance protection as set out in the Ohio Administrative Code. Refer to the 3-way contract for specific requirements.

## G. INCENTIVES AND WITHHOLDS

### i. Incentives

There are no bonuses or incentives offered in the MyCare Ohio program.

### ii. Withholds

Withholds constitute 2% of the certified rates. Attachment 1 illustrates the development of the guaranteed rates as a 2% reduction from the certified rates.

### iii. Estimate of percent to be returned

The MyCare program is new and the estimated amount of withhold return is uncertain.

### iv. Effect on the capitation rates

The rate is certified as actuarially sound assuming the withhold is not returned.

## 8. OTHER RATE DEVELOPMENT CONSIDERATIONS

### A. DIFFERENT FMAP

None of the MyCare population groups are eligible for an FMAP higher than the regular FMAP.

### B. ACTUARIALLY ACCEPTED PRACTICES AND PRINCIPLES

#### i. Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To our knowledge, there are no reasonable, appropriate, and attainable costs that have not been included in the certification.

## ii. Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process, with the exception of the budget neutral MEMA adjustment described in Section 7.

## iii. Rates within ranges

The final contracted rates will match the final certified capitation rates, with the exception of the budget neutral MEMA adjustment methodology, the capitation withholds, and the capitation incentives described in Section 7.

# 9. PROCEDURES FOR RATE CERTIFICATION AND CONTRACT AMENDMENTS

In general, a new rate certification will be submitted when the rates change materially. The following exceptions are noted:

1. A contract amendment that does not affect the capitation rates.
2. Risk adjustment, under a methodology described in the initial certification, changes the rates paid to the plans, but contracted rates still fall within the certified rate ranges for the contract period. Note that rate ranges were not employed for the MyCare program.

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

### 1. MANAGED LONG-TERM SERVICES AND SUPPORTS

#### A. COMPLETION OF SECTION I.

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

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

#### B. MLTSS RATE STRUCTURE

##### (a) Capitation Rate Structure

The MyCare Ohio rate structure for calendar year 2016 did not change from the 2015 rate structure. Rates continue to vary by region consistent with current geographic definitions. The NFLOC rate cell continues to reflect a composite of the institutional, community waiver 18 – 44, community waiver 45 – 64 and community waiver 65+ population groups. The NFLOC rate cell will be adjusted by the MEMA (discussed more in Section I7) on a semi-annual basis. The community well population groups includes three separate rate cells: community well 18 – 44, community well 45 – 64, and community well 65+ for a total of four MyCare Ohio rate cells.

##### Community Well

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

##### NFLOC

The NFLOC category represents MyCare-eligible members (as outlined earlier) who are eligible for or enrolled in one of the following populations:

- Ohio Medicaid HCBS waiver program
  - MyCare Waiver
  - Assisted Living
  - Choices (program has been discontinued, but was in place during FFS data period)
  - Ohio Home Care
  - PASSPORT
  - Transitions II (program has been discontinued, but was in place during FFS data period)
- Long-term nursing facility (NF) resident (i.e. institutional)
  - An individual must have 100 or more consecutive days in a NF based on Medicare and Medicaid days to be considered a resident of a NF.
  - Gaps in NF care of 15 days or less per discharge count toward the consecutive day requirement.
  - Any days that a member spends in an inpatient hospital setting, once already admitted to a NF, count toward the 100 day requirement.

Once a Medicaid recipient achieves the one-hundredth NF day (regardless of payer), the member is assigned to the NFLOC rate cell in the subsequent month and the plan would then be paid the higher rate associated with this population. NF residents that have been in a NF for 100 or more days immediately preceding that member's enrollment in the MyCare program will be classified into the NFLOC rate cell on the first day of enrollment. Enrollees who transition from a HCBS waiver to a NF will remain in the NFLOC rate cell; however, for population group stratification in the capitation rate development process and the MEMA adjustment, these individuals continue in the community waiver population group until the one-hundredth institutional day requirement is met.

There was insufficient data for Medicare Part C enrollees to determine the number of days since an individual was admitted to a NF. The rate cell definitions assume all MyCare-eligible members who are enrolled in a Medicare Part C plan and also admitted to a NF when enrolling in the MyCare program have incurred 8 consecutive days in a NF. The 8-day assumption was derived from the distribution of actual Medicare versus Medicaid days for Non-Part C enrollees who started and ended their 100 day threshold count during the base data year.

For the NFLOC rate cell, there is a single rate cell for each contracting region. The rates were developed using data from the following NFLOC population groups: institutional, community waiver 18 - 44, community waiver 45 - 64 and community waiver 65+.

August 2015 enrollment in MyCare Ohio will be used as a basis for the projected enrollment distribution by population group for calendar year 2016. The composite NFLOC rates reflect the anticipated mix of NFLOC members achieved through effective managed care activities.

#### **Transition Rules**

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

#### **(b) Methodology**

The structure, rationale, and payment methodology are discussed in (a) above.

### **C. MANAGED CARE EFFECT**

The blended nature of the NFLOC rate cell encourages MCOPs to manage the mix of the population towards lower cost settings. This is the basis for efficiencies in LTSS programs. This transition between settings (e.g. nursing facility to HCBS waiver services) is gradual in nature and is not an immediate transition. Most often, individuals that are in a nursing facility for a long period of time have lost their community supports and it becomes difficult to change the setting away from a nursing facility. Therefore, MCOPs will need to seek individuals that are newer to LTSS benefits and avoid or delay nursing facility placement. Because of this, we assumed gradual increases in HCBS percentages and decreases in nursing facility percentages. Our assumption for CY 2016 is that the average mix between HCBS and nursing facility will shift by 1% in favor of HCBS for the year.

### **D. NON-BENEFIT COST**

The non-benefit cost assumptions are discussed in Section I5. The non-benefit costs vary by population group and are appropriate for the MLTSS benefits and services.

### **E. EXPERIENCE AND ASSUMPTIONS**

Section I details the experience and assumptions employed for the MLTSS and non-MLTSS services included in the MyCare program.

## LIMITATIONS

The information contained in this report has been prepared for the Ohio Department of Medicaid (ODM) to provide documentation of the development of the CY 2016 actuarially sound rate range for the MyCare Ohio program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this letter will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for ODM by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman relied upon certain data and information provided by ODM and their vendors, primarily the historical claims and eligibility for MyCare eligible FFS members. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

The services provided by Milliman to ODM were performed under the signed contract agreement between Milliman and ODM dated June 11, 2015.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The actuaries preparing this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

## **ATTACHMENT 1: CERTIFIED RATES**

**Ohio Department of Medicaid  
MyCare Managed Care Program  
CY 2016 Opt-Out Certified Rates**

<b>Population Group:</b>	<b>NFLOC Total</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 4,381.27	\$ 87.63	\$ 4,293.65
East Central	3,692.62	73.85	3,618.77
Northeast	4,134.14	82.68	4,051.46
Northeast Central	3,987.77	79.76	3,908.02
Northwest	4,133.51	82.67	4,050.84
Southwest	4,586.19	91.72	4,494.46
<u>West Central</u>	<u>3,422.88</u>	<u>68.46</u>	<u>3,354.43</u>
<b>Statewide Total</b>	<b>\$ 4,057.60</b>	<b>\$ 81.15</b>	<b>\$ 3,976.45</b>

<b>Population Group:</b>	<b>Community Well 18-44</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 593.97	\$ 11.88	\$ 582.09
East Central	365.61	7.31	358.30
Northeast	443.48	8.87	434.61
Northeast Central	303.84	6.08	297.76
Northwest	418.23	8.36	409.86
Southwest	388.74	7.77	380.96
<u>West Central</u>	<u>405.67</u>	<u>8.11</u>	<u>397.55</u>
<b>Statewide Total</b>	<b>\$ 426.02</b>	<b>\$ 8.52</b>	<b>\$ 417.50</b>

<b>Population Group:</b>	<b>Community Well 45-64</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 697.99	\$ 13.96	\$ 684.03
East Central	425.18	8.50	416.67
Northeast	517.46	10.35	507.11
Northeast Central	351.22	7.02	344.20
Northwest	488.00	9.76	478.24
Southwest	452.49	9.05	443.44
<u>West Central</u>	<u>472.69</u>	<u>9.45</u>	<u>463.24</u>
<b>Statewide Total</b>	<b>\$ 494.50</b>	<b>\$ 9.89</b>	<b>\$ 484.61</b>

<b>Population Group:</b>	<b>Community Well 65+</b>		
<b>Region</b>	<b>Full Medicaid Rate</b>	<b>Quality Withhold</b>	<b>Guaranteed Rate</b>
Central / Southeast	\$ 998.00	\$ 19.96	\$ 978.04
East Central	1,010.85	20.22	990.63
Northeast	823.97	16.48	807.49
Northeast Central	778.98	15.58	763.40
Northwest	762.40	15.25	747.15
Southwest	1,113.75	22.28	1,091.48
<u>West Central</u>	<u>1,091.21</u>	<u>21.82</u>	<u>1,069.38</u>
<b>Statewide Total</b>	<b>\$ 944.53</b>	<b>\$ 18.89</b>	<b>\$ 925.64</b>

## **APPENDIX F**

This Appendix is intentionally blank.

## **APPENDIX G MYCARE COVERAGE AND SERVICES**

### 1. Basic Benefit Package

After consideration of third party liability including Medicare coverage pursuant to OAC rules 5160-58-01.1 and 5160-26-09.1, a MyCare Ohio Plan (MCOP) must ensure that its members have access to all medically-necessary medical, drug, behavioral health, nursing facility and home and community-based waiver services covered by Medicaid pursuant to OAC rule 5160-58-03(A), with limited exclusions, limitations and clarifications [see OAC rule 5160-58-03(H) and section G.2 of this Appendix]. An MCOP must also ensure that its members have access to any additional services specified in this Agreement. For information on Medicaid-covered services, MCOPs must refer to the Ohio Department of Medicaid (ODM) website.

Services covered by the MCOP benefit package include, but are not limited to the following:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinics (RHCs) and federally qualified health centers (FQHCs)
- Physician services whether furnished in the physician's office, the covered person's home, a hospital, or elsewhere
- Laboratory and x-ray services
- Screening, diagnosis, and treatment services to children under the age of twenty-one (21) under the Healthchek, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program
- Family planning services and supplies
- Home health and private duty nursing services
- Podiatry
- Chiropractic services
- Physical therapy, occupational therapy, developmental therapy, and speech therapy
- Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse

practitioner services

- Free-standing birth center services in free-standing birth centers as defined in OAC 5160-18-01
- Prescription drugs
- Ambulance and ambulette services
- Dental services
- Durable medical equipment and medical supplies, including expedited wheelchair fitting, purchase, maintenance and repair, professional evaluation, home assessment, the services of skilled wheelchair technicians, pick-up and delivery, timely repairs, training, demonstration and loaner chairs.
- Vision care services, including eyeglasses
- Nursing facility services
- Hospice care
- Behavioral health services, including the following behavioral health services provided by the Ohio Department of Mental Health and Addiction Services (MHAS)-certified providers:
  - Behavioral Health Assessment
  - Behavioral Health Counseling and Therapy (Individual and Group)
  - Crisis Intervention (24-hour availability)
  - Partial Hospitalization
  - Inpatient psychiatric hospitalization in free-standing and state-operated psychiatric hospitals (see limitations in section G.2.b.iii of this appendix)
  - Community Psychiatric Support Treatment (Individual and Group)
  - Ambulatory Detoxification
  - Targeted Case Management for AOD
  - Intensive Outpatient Programs (IOP)
  - Laboratory Urinalysis
  - Medication/Somatic Treatment Services
  - Methadone Administration
- Immunizations [\*An MCOP must follow the coverage requirements provided by ODM for any newly approved vaccine under the Vaccines for Children (VFC) program]
- Preventive services covered by Ohio Medicaid in accordance with Section 4106 of

the Affordable Act and 42 CFR 440.130(c).

- All U.S. Preventive Services Task Force (USPSTF) grade A and grade B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration, without cost-sharing, as provided in section 4106 of the Affordable Care Act. Additionally, MCOPs must cover, without cost-sharing, services specified under Public Health Service Act section 2713, in alignment with the Alternative Benefit Plan.
- Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit, as described in OAC rule 5160-4-34.
- Telemedicine
- Home and community-based waiver services specified below using providers that are certified by the Ohio Department of Aging (ODA) or approved by ODM and meet the requirements in Chapters 173-39 or 5160-45 of the Administrative Code, as appropriate:
  - Adult Day Health
  - Homemaker
  - Personal Care
  - Alternative Meals Service
  - Assisted Living Service
  - Home Care Attendant Service
  - Chore Services
  - Community Transition Service
  - Emergency Response Services
  - Enhanced Community Living Service
  - Home Care Attendant
  - Home Delivered Meals
  - Home Medical Equipment and Supplemental Adaptive and Assistive Device Services (contingent upon the completion of an evaluation from a licensed health care professional, occupational therapist, physical therapist or other skilled therapist, as appropriate to the service being rendered).
  - Home Modification, Maintenance and Repair (contingent upon the evaluation from a licensed physical therapist or occupational therapist to evaluate the need for home modification, maintenance and repair services for members).
  - Independent Living Assistance
  - Nutritional Consultation
  - Out-of-Home Respite
  - Pest Control
  - Social Work Counseling
  - Waiver Nursing Service
  - Waiver Transportation

2. Exclusions, Limitations and Clarifications

a. Exclusions

An MCOP is not required to pay for services not covered by the Medicaid program, except as otherwise specified in OAC rule 5160-58-03 and/or this Agreement. Information regarding Medicaid non-covered services can be found on the ODM web site. Services not covered by the Medicaid program include, but are not limited to, the following:

- Services or supplies that are not medically necessary
- Treatment of obesity unless medically necessary
- Experimental services and procedures, including drugs and equipment not covered by Medicaid, and not in accordance with customary standards of practice.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
- Infertility services for males or females
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
- Reversal of voluntary sterilization procedures
- Plastic or cosmetic surgery that is not medically necessary (\*These services could be deemed medically necessary if medical complications/conditions in addition to the physical imperfection are present).
- Sexual or marriage counseling
- Acupuncture and biofeedback services
- Services to find cause of death (autopsy) or services related to forensic studies
- Paternity testing
- Services determined by another third-party payor as not medically necessary.
- Drugs not covered by the Ohio Medicaid pharmacy program as specified in OAC 5160-9-03, including drugs for the treatment of obesity.

- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual. Assisted suicide services do not include withholding or withdrawing medical treatment, nutrition or hydration or the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death.
- Medical services if the service was caused by a provider-preventable condition as defined in 42 CFR 447.26. The prohibition on payment for provider-preventable conditions shall not result in a loss of access to care or services for Medicaid consumers.
- An MCOP is not required to pay for non-emergency services or supplies provided by non-panel providers, unless the member has followed the instructions in the MCOP member handbook for seeking coverage of such services, or unless otherwise directed by ODM.

b. Limitations & Clarifications

i. Member Cost-Sharing

As specified in Appendix A, Section 3.3 of the Three-Way, an MCOP may elect to implement co-payments for Medicaid-covered drugs, but shall not charge cost sharing to members above levels established under the Medicare Part D Low Income Subsidy. Pursuant to Appendix C, Section 3.3(C) of the Three-Way, members who reside in a nursing facility (NF) or are enrolled in the MyCare 1915(c) waiver may be required to contribute to the cost of care the amount of patient liability established by the County Department of Job and Family Services.

ii. Abortion and Sterilization

The use of federal funds to pay for abortion and sterilization services is prohibited unless the specific criteria found in federal law and OAC rules 5160-17-01 and 5160-21-02.2 are met. An MCOP must verify that all of the information on the applicable required forms [ODM 03197, ODM 03199, HHS-687 and HHS-687-1 (SPANISH VERSION)] is provided and that the service meets the required criteria before any such claim is paid.

Additionally, payment must not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion or sterilization itself does not qualify for payment. The MCOP is responsible for educating its providers on the requirements; implementing internal procedures including systems edits to ensure that claims are only paid once the MCOP has determined if the applicable forms are completed and the required criteria are met, as

confirmed by the appropriate certification/consent forms; and for maintaining documentation to justify any such claim payments. If the MCOP has made the determination that the requirements associated with an abortion, sterilization, or hysterectomy were sufficiently met by the facility/provider, then no additional information (i.e. operative notes, history and physical, ultrasound etc.) is required from ancillary providers.

iii. Behavioral Health Services Limitations

An MCOP is not responsible for providing mental health services to persons between 22 and 64 years of age while residing in an institution for mental disease (IMD) as defined in Section 1905(i) of the Social Security Act. The MCOP is not prohibited from contracting with an IMD to provide mental health services to persons between 22 and 64 years of age, but the MCOP will not be compensated by Medicaid for the provision of such services (i.e. either through direct payment or considering any associated costs in the Medicaid rate setting process).

- iv. Organ Transplants: An MCOP must ensure coverage for organ transplants and related services in accordance with OAC 5160-2-07.1 (B)(4) & (5). Coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the “Ohio Solid Organ Transplant Consortium” based on criteria established by Ohio organ transplant surgeons and authorization from the ODM prior authorization unit. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC 3701-84-01, is contingent upon review and recommendation by the “Ohio Hematopoietic Stem Cell Transplant Consortium” based on criteria established by Ohio experts in the field of bone marrow transplant. While an MCOP may require prior authorization for these transplant services, the approval criteria must be limited to confirming that the consumer is being considered and/or has been recommended for a transplant by either consortium. Additionally, in accordance with OAC 5160-2-03(A)(4) all services related to organ donations are covered for the donor recipient when the consumer is Medicaid eligible.

3. Information Sharing with Non-Panel Providers

To assist members in accessing medically-necessary Medicaid-covered services, an MCOP is required to share specific information with certain non-panel providers. The information is to assist non-panel providers to recognize MCOP membership, access information needed to provide services and, if applicable, successfully submit claims to the MCOP.

a. ODM-Designated Providers

In accordance with OAC rules 5160-58-01.1 and 5160-26-03.1, the MCOP must share specific information with FQHCs/RHCs, qualified family planning providers [QFPPs], hospitals and if applicable, certified nurse

midwives [CNMs], certified nurse practitioners [CNP], and free-standing birth centers (FBCs) as defined in OAC 5160-18-01 within the MCOP's service area and in bordering regions if appropriate based on member utilization information. The information must be shared within the first month after the MCOP has been awarded a Medicaid provider agreement for a specific region and annually thereafter. At a minimum, the information must include the following:

- the information's purpose;
- claims submission information including the MCOP's Medicaid provider number for each region (this information is only required to be provided to non-panel FQHCs/RHCs, QFPPs, CNMs, CNPs and hospitals);
- the MCOP's prior authorization and referral procedures;
- a picture of the MCOP's member ID card (front and back); and
- contact numbers for obtaining information for eligibility verification, claims processing, referrals/prior authorization, post-stabilization care services and if applicable information regarding the MCOP's behavioral health administrator;
- a listing of the MCOP's laboratories and radiology providers.

b. MCOP-authorized Providers

In accordance with OAC rules 5160-58-01.1 and 5160-26-05, an MCOP authorizing the delivery of services from a non-panel provider must ensure that it has a mutually agreed upon compensation amount for the authorized service and must notify the provider of the applicable provisions of OAC rules 5160-58-01.1 and 5160-26-05. This notice is provided when an MCOP authorizes a non-panel provider to furnish services on a one-time or infrequent basis to an MCOP member and must include required ODM-model language and information.

**APPENDIX H  
MYCARE OHIO  
PROVIDER PANEL SPECIFICATIONS**

**1. FEDERAL ACCESS STANDARDS**

A MyCare Ohio Plan (MCOP) must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as ensure that it is in compliance with the following federally defined provider panel access standards as required by 42 CFR 438.206:

In establishing and maintaining its provider panel, the MCOP must consider the following:

- The anticipated Medicaid membership.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the MCOP.
- The number and types (in terms of training, experience, and specialization) of panel providers required to deliver the contracted Medicaid services.
- The geographic location of panel providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.
- The MCOP must adequately and timely cover services from an out-of-network provider if the MCOP's contracted provider panel is unable to provide the services covered under the MCOP's provider agreement. The MCOP must cover the out-of-network services for as long as the MCOP network is unable to provide the services. The MCOP must coordinate with the out-of-network provider with respect to payment and ensure that the provider agrees with the applicable requirements.

Contracting providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. The MCOP must ensure that services are available 24 hours a day, 7 days a week, when medically necessary. The MCOP must establish mechanisms to ensure that panel providers comply with timely access requirements, and must take corrective action if there is failure to comply.

In order to comply with 42 CFR 438.206 and 438.207 and demonstrate adequate provider panel capacity and services, the MCOP must submit documentation as specified to the Ohio Department of Medicaid (ODM), in a format specified by ODM, demonstrating that the MCOP offers an appropriate range of preventive, primary care, specialty, behavioral health and waiver services adequate for the anticipated number of members in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of

the number of members in the service area. This documentation of assurance of adequate capacity and services

must be submitted to ODM no less frequently than at the time the MCOP enters into a contract with ODM; at any time there is a significant change (as defined by ODM) in the MCOP's operations that would affect adequate capacity and services (including changes in services, benefits, geographic service or payments); and at any time there is enrollment of a new population in the MCOP.

When a waiver enrollee expresses a preference for an independent (non-agency) provider for an eligible service identified on the member's waiver service plan, the MCOP must seek out an available independent provider. The MCOP must offer the independent provider a contract for provision of the services to the member when the provider is willing, acceptable to the member, and appropriate to the member's care, and approved by ODM/ODA with an active Medicaid provider agreement to render services in accordance with OAC Chapters 173-39 and 5160-45 as appropriate.

## **2. GENERAL PROVISIONS**

MCOP must meet requirements as specified in Section 2.7.9 of the Three-Way and this appendix including, but not limited to, Section 4 Provider Panel Requirements of this appendix. The MCOP must remain in compliance with these requirements for the duration of this Provider Agreement.

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

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

In developing the provider panel requirements, ODM considered the population size and the potential availability of the designated provider types. ODM integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODM requires providers to be located anywhere in the region or within a set number of miles from a zip code.

The MCOP must ensure that providers submitted to the Managed Care Provider Network (MCPN), or listed in MCOP published directories, are available to both dual benefits and Medicaid only members of the MCOP.

ODM will recalculate the minimum provider panel specifications if ODM determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population. The Managed Care Provider Network (MCPN) is the tool

that will be used for ODM to determine if the MCOP meets all the panel requirements that are identified within Appendix H; therefore the plans must enter all network providers as specified within the file specs.

On at least a monthly basis, ODM or its designee will provide each MCOP with an electronic file containing the MCOP's provider panel as reflected in the ODM MCPN database, or other designated system.

### **3. PROVIDER SUBCONTRACTING**

Unless otherwise specified in this appendix or OAC rules 5160-58-01.1 and 5160-26-05, an MCOP is required to enter into fully-executed subcontracts with its providers. These subcontracts must include a baseline contractual agreement, as well as the appropriate ODM-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable OAC rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCOP's name.

The MCOP may not employ or contract with providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act. Only those providers who meet the applicable criteria specified in this document, and as determined by ODM, will be counted toward meeting minimum panel requirements. The MCOP must credential and -re-credential providers in accordance with OAC rules 5160-58-01.1 and 5160-26-05. The MCOP must ensure that the provider has met all applicable credentialing criteria before the provider can be listed as a panel provider. At the direction of ODM, the MCOP must submit documentation verifying that all necessary contract documents have been appropriately completed.

The MCPN is a centralized database system that maintains information on the status of MCOP-submitted providers. At a minimum, the MCOP must submit providers associated with the provider types specified in this Appendix, which includes Sections 2.6 and 2.7 of the Three-Way with the exception of independent providers. The MCOP must notify ODM of the addition and deletion of its contracting providers as specified in OAC rules 5160-58-01.1 and 5160-26-05, and must notify ODM within one working day, in instances where the MCOP has identified that it is not in compliance with the provider panel requirements specified in this appendix. For provider deletions, the MCOP must complete and submit an electronic record terminating the provider from the MCPN or other designated system.

#### **4. PROVIDER PANEL REQUIREMENTS**

Failure to contract with, and properly report to the MCPN, the minimum necessary panel will result in sanctions as outlined in Appendix N. ODM will grant an ‘exception to the issuance of sanction’ only when an action taken by ODM has adversely impacted a plan’s ability to meet the provider panel network or when a provider is not available in the required zip code, county, and/or region.

All MCOPs must provide all medically-necessary Medicaid-covered services to their members. MCOPs must ensure that all network providers follow community standards in the scheduling of routine appointments (i.e., the amount of time members must wait from the time of their request to the first available time when the visit can occur).

The MCOP must comply with all provider network requirements set forth in the Three-Way and the provider network requirements included as part of this appendix except as explicitly noted herein.

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

*Vision Care Providers* - MCOPs must contract with at least the minimum number of ophthalmologists and optometrists for each specified county and region, all of whom must maintain a full-time practice at a site(s) located in the specified county and region to count toward minimum panel requirements. All ODM-approved vision providers must regularly perform routine eye exams. MCOPs will be expected to contract with an adequate number of ophthalmologists as part of its overall provider panel, but only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care provider panel requirement. If optical dispensing is not sufficiently available in a region through the MCOP’s contracting ophthalmologists/optometrists, the MCOP must separately contract with an adequate number of optical dispensers located in the region.

*Dental Care Providers* - MCOPs must contract with at least the minimum number of dentists.

*Waiver Providers*: The MCOP shall ensure that MyCare HCBS waiver providers listed in the charts within Appendix H meet the requirements set forth in OAC Chapters 173-39 and 5160-45, as appropriate, and have an active Medicaid provider agreement with ODM. ODM will not issue compliance for violation of the minimum standards reflecting in the chart labeled “Waiver Providers” of this appendix until after July 1, 2015, but MCOPs must ensure coverage of these services to their members.

The MCOP must have a written policy setting forth a regular payment cycle for clean claims submitted by independent providers. The MCOP must adhere to the policy and any communications from the MCOP to a provider must be consistent with the policy.

*Nursing Facilities:* The MCOP must contract with at least the minimum number of facilities that are identified in the attached Appendix H chart. However, ODM will not issue compliance for violation of the minimum standards reflecting in the chart labeled “Nursing Facility” of this appendix until after July 1, 2015, but MCOPs must ensure coverage of these services to their members.

*Behavioral Health Providers:* MCOPs must evaluate each region’s network capacity of behavioral health services (both Medicare and Medicaid). An MCOP must perform an assessment of no less than its contracted Medicare providers in each region and county regarding providers’ willingness and preparedness to become Medicaid providers of the behavioral health services. The MCOP must also assess whether each region and county’s CMHC’s are currently certified for Medicare or are prepared and willing to pursue certification for Medicare services. MCOP’s must report the results to ODM upon request.

*Alcohol and Drug Providers:* The MCOP must contract with at least the minimum number of certified Ohio Department of Mental Health and Addiction Services providers identified on the Appendix H charts. In addition, MCOP must ensure there exist adequate provider panel capacity to provide its members with reasonable and timely access to the following services; alcohol/drug screening analysis/lab urinalysis, ambulatory detoxification, assessment, case management, crisis intervention, individual counseling, group counseling, induction of buprenorphine, injection of naltrexone (to treat addiction), intensive outpatient (to treat addiction) and medical somatic services. ODM will not issue compliance for violation of the minimum standards reflected in the chart until after July 1, 2015, but MCOPs must ensure coverage of these services to their members.

*Mental Health Provider:* MCOPs must contract with at least the minimum number of certified Ohio Department of Mental Health and Addiction Services providers identified on the Appendix H charts. In addition, MCOPs must ensure adequate provider panel capacity to provide its members with reasonable and timely access to the following services within the region, if available; Community Psychiatric Supportive Treatment, Crisis Intervention, Health Home Comprehensive Care Coordination, individual counseling, group counseling, injections (long-acting antipsychotic medications), mental health assessment, partial hospitalization, pharmacological management, psychiatric diagnostic interview and psychological testing. ODM will not issue compliance for violation of the minimum standards reflecting in the chart until after December 31, 2015, but MCOPs must ensure coverage of these services to their members.

## **5. PROVIDER DIRECTORIES**

An MCOP’s provider directory must include all MCOPN-contracted providers as well as certain non-contracted providers as specified by ODM with the exception of independent providers and

those providers operating under single case agreements. At the time of ODM's review, the information listed in the MCOP's provider directory for all ODM-required provider types specified on the attached charts must exactly match the data currently on file in the ODM MCPN, or other designated process.

The MCOP's provider directory must utilize a format specified by ODM. The directory may be region-specific or include multiple regions; however, the providers within the directory must be divided by region, county, and provider type, in that order.

**The directory must also specify:**

- Provider address(es) and phone number(s);
- An explanation of how to access providers (e.g. referral required vs. self-referral);
- An indication of which providers are available to members on a self-referral basis;
- Foreign-language speaking PCPs and specialists and the specific foreign language(s) spoken;
- How members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals including but not limited to, visually-limited, LEP, and LRP eligible individuals, any PCP or specialist practice limitations; and
- An indication of whether the provider is accepting new members.

**Printed Provider Directory**

Prior to executing a provider agreement with ODM, the MCOP must develop a printed provider directory that complies with requirements set forth in Section 2.12.5.2 of the Three-Way and is prior-approved by ODM. Once approved, this directory may be regularly updated with provider additions or deletions by the MCOP without ODM prior-approval; however, a copy of the revised directory (or inserts) must be submitted to ODM prior to distribution to members.

On a quarterly basis, the MCOP **must** create an insert to each printed directory that lists those providers **deleted** from the MCOP's provider panel during the previous three months.

**Internet Provider Directory**

The MCOP is required to have an internet-based provider directory available in a format prior approved by ODM. This internet directory must allow members to electronically search for MCOP panel providers based on name, provider type, and geographic proximity. If an MCOP has one internet-based directory for multiple populations, each provider must include a description of which population they serve.

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 with this appendix. Providers required by ODM, or by the Three-Way, **must** be added to the internet directory within one week of submitting the provider to the MCPN. Providers being deleted from the MCOP's panel must be deleted from the internet directory within one week of notification from the provider to the MCOP. Providers being deleted from the MCOP's panel must be posted to the internet directory within one week of notification from the provider to the MCOP of the deletion. These deleted providers must be included in the inserts to the MCOP's printed provider directory referenced above.

WAIVER PROVIDERS

MyCare Region	Chore Services	Community Transition	Emergency Response	Home Medical Equipment & Supplies	Home Modifications	Homemaker	Independent Living Assistance	Meals Home Delivered	Nutritional Counseling	Out of Home Respite	Social Work Counseling	Waiver Transportation	Waiver Nursing Agency	Personal Care- Agency
Central	1	5	19	19	8	56	2	9	1	1	2	2	42	124
East Central	2	7	10	10	15	24	2	9	2	1	2	6	22	53
Northeast	1	7	16	6	6	34	0	13	2	2	2	8	28	63
Northeast Central	2	8	5	4	2	10	5	5	3	1	2	2	10	31
Northwest	1	1	3	3	2	4	2	10	2	2	2	2	20	30
Southwest	1	8	10	6	7	16	2	19	4	1	2	4	21	44
West Central	6	4	4	7	8	6	0	8	6	1	2	5	28	41

**Nursing Facility-MyCare Provider Panel Analysis**

<b>MyCare Region</b>	<b>County</b>	<b># NF</b>
Central	Delaware	3
Central	Franklin	16
Central	Madison	1
Central	Pickaway	2
Central	Union	1
East Central	Portage	2
East Central	Stark	11
East Central	Summit	14
East Central	Wayne	5
Northeast	Cuyahoga	31
Northeast	Geauga	2
Northeast	Lake	4
Northeast	Lorain	4
Northeast	Medina	4
Northeast Central	Columbiana	5
Northeast Central	Mahoning	7
Northeast Central	Trumbull	7
Northwest	Fulton	2
Northwest	Lucas	12
Northwest	Ottawa	2
Northwest	Wood	4

<b>MyCare Region</b>	<b>County</b>	<b># NF</b>
Southwest	Butler	7
Southwest	Clermont	4
Southwest	Clinton	1
Southwest	Hamilton	23
Southwest	Warren	6
West Central	Clark	4
West Central	Greene	3
West Central	Montgomery	12
	<b>Grand Total</b>	<b>199</b>

MyCare Region	OMHAS Mental Health Providers	OMHAS Alcohol & Drug Providers
Central	18	8
East Central	19	8
Northeast	50	8
Northeast Central	10	6
Northwest	10	6
Southwest	28	8
West Central	19	6

	Vision	Dental
<b>Northeast</b>		
Cuyahoga	32	85
Geauga	0	1
Lake	2	7
Lorain	3	13
Medina	1	4
<b>Total</b>	<b>38</b>	<b>110</b>

	Vision	Dental
<b>East Central</b>		
Portage	0	3
Stark	7	17
Summit	11	23
Wayne	0	3
<b>Total</b>	<b>18</b>	<b>46</b>

<b>Northeast Central</b>		
Columbia	0	2
Mahoning	5	11
Trumbull	4	8
<b>Total</b>	<b>9</b>	<b>21</b>

<b>Central</b>		
Delaware	3	3
Franklin	20	60
Madison	0	1
Pickaway	1	1
Union	1	1
<b>Total</b>	<b>25</b>	<b>66</b>

<b>Northwest</b>		
Fulton	0	2
Lucas	9	26
Ottawa	0	1
Wood	2	2
<b>Total</b>	<b>11</b>	<b>31</b>

<b>Southwest</b>		
Butler	4	13
Clermont	1	5
Clinton	1	1
Hamilton	14	34
Warren	2	3
<b>Total</b>	<b>22</b>	<b>56</b>

<b>West Central</b>		
Clark	3	6
Greene	3	3
Montgomery	13	23
<b>Total</b>	<b>19</b>	<b>32</b>

## APPENDIX I

### PROGRAM INTEGRITY

MCOPs must comply with all applicable state and federal program integrity requirements, including, but not limited to, those specified in 42 CFR 455 and 42 CFR 438 Subpart H.

1. Fraud and Abuse Program:

In addition to the specific requirements of OAC rules, 5160-58-01.1 and 5160-26-06, the MCOP must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan to guard against fraud and abuse. The MCOP's compliance plan must designate staff responsibility for administering the plan and include clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and explain how the MCOP will determine the compliance plan's effectiveness.

In addition to the requirements in OAC rules 5160-58-01.1 and 5160-26-06, and in accordance with ODM's 1915(c) and 1915(b) CMS-approved waiver, the MCOP's compliance program which safeguards against fraud and abuse must, at a minimum, specifically address the following:

- a. Employee education about false claims recovery: In order to comply with Section 6032 of the Deficit Reduction Act of 2005 MCOPs must, as a condition of receiving Medicaid payment, do the following:
  - i. Establish and make readily available to all employees, including the MCOP's management, the following written policies regarding false claims recovery:
    - a. Detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil or criminal penalties;
    - b. The MCOP's policies and procedures for detecting and preventing fraud, waste, and abuse; and
    - c. The laws governing the rights of employees to be protected as whistleblowers.
  - ii. Include in any employee handbook the required written policies regarding false claims recovery;
  - iii. Establish written policies for any MCOP contractors and agents that provide detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse,

including administrative remedies for false claims and statements as well as civil or criminal penalties; the laws governing the rights of employees to be protected as whistleblowers; and the MCOP's policies and procedures for detecting and preventing fraud, waste, and abuse. MCOP must make such information readily available to their subcontractors; and

- iv. Disseminate the required written policies to all contractors and agents, who must abide by those written policies.
- b. Monitoring for fraud and abuse: The MCOP's program which safeguards against fraud and abuse must specifically address the MCOP's prevention, detection, investigation, and reporting strategies in at least the following areas:
- i. Credible allegations of fraud: The MCOP must monitor activities on an ongoing basis to prevent and detect activities involving suspected fraud, embezzlement, and theft (e.g., by staff, providers, contractors, etc.) and report promptly as specified in this appendix.
  - ii. Underutilization of services: In order to assure that all Medicaid-covered services are being provided, as required, the following areas must be monitored:
    - a. The MCOPs must annually review their prior authorization (PA) procedures to determine if they unreasonably limit a member's access to Medicaid-covered services;
    - b. The MCOPs must annually review their appeals process for providers following the MCOP's denial of a prior authorization request to determine if the appeals process unreasonably limits a member's access to Medicaid-covered services;
    - c. The MCOPs must monitor, on an ongoing basis, service denials and utilization in order to identify member services which may be underutilized; and
    - d. If any underutilized services or limits to a member's access to Medicaid-covered services are identified, the MCOP must immediately investigate and, if indicated, correct the problem(s).
  - iii. Claims submission and billing: On an ongoing basis, the MCOP must identify and correct claims submission and billing activities which are potentially fraudulent including, at a minimum, double-billing and improper coding, such as upcoding and unbundling, to the satisfaction of the Ohio Department of Medicaid (ODM).

Reporting MCOP monitoring of fraud and abuse activities: Pursuant to OAC rules 5160-58-01.1 and 5160-26-06, the MCOP is required to report annually to ODM a summary of

the MCOP's monitoring of credible allegations of fraud and abuse, underutilization of member services, limits to Medicaid-covered services, and suspicious claims submission and billing. The MCOP's report must also identify any proposed changes to the MCOP's compliance plan for the coming year.

- c. Reporting suspected fraud and abuse: MCOPs are required to promptly report all instances of suspected provider and member fraud and abuse.
  - i. Credible allegation of provider fraud: MCOPs must promptly refer suspected cases of provider fraud in the ODM specified form to ODM for investigation and determination of whether a credible allegation of fraud exists. If a credible allegation of fraud exists, at the direction of ODM, the MCOP must immediately suspend all payments to the provider and must immediately suspend the provider in accordance with ORC 5164.36. At the request of ODM staff, ODM's designee, the Ohio Attorney General's Office or federal agencies, the MCOP must produce copies of all MCOP fraud, waste and abuse investigatory files and data (including, but not limited to records of recipient and provider interviews) within thirty calendar days unless otherwise agreed upon by ODM.
  - ii. Credible allegation of member fraud: MCOPs are required to promptly report all suspicions of member fraud to ODM for investigation by e-mail to [Program\\_Integrity\\_County\\_Referral@medicaid.ohio.gov](mailto:Program_Integrity_County_Referral@medicaid.ohio.gov) and copy the appropriate County Department of Job and Family Services (CDJFS).
- d. Attestations: The MCOP must respond to ODM-initiated fraud, waste and abuse referrals with attestations in the form specified by ODM within 90 calendar days of referral receipt.
- e. Monitoring for prohibited affiliations: The MCOP's policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the MCOP will not knowingly have a relationship with individuals debarred by Federal Agencies, as specified in Article XII of the Agreement.
- f. The MCOP must disclose to ODM any information regarding change in ownership and control within 35 days in accordance with 42 CFR 455.104 and 5160-1-17.3.
- g. In accordance with 42 CFR 455.105, the MCOP must submit within 35 days of the date requested by ODM or HHS full and complete information about:
  - i. The ownership of any subcontractor with whom the MCOP has had business transactions totaling more than \$25, 000 during the 12-month period ending on the date of the request.

- ii. Any significant business transactions between the MCOP and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
- h. The MCOP must disclose the following information on persons convicted of crimes in accordance with 42 CFR 455.106 who:
- i. Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
  - ii. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

This information must also be disclosed at any time upon written request by the Medicaid agency. The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure referenced in this section.

- i. In accordance with 42 CFR 1002.3(b), MCOPs must notify ODM when the MCOP denies credentialing to a provider for program integrity reasons.
  - j. An MCOP that is not a qualified health maintenance organization must report to ODM a description of certain transactions with parties of interest as outlined in section 1903(m)(4)(A) of SSA [42 U.S.C. 1396b(m)(4)(A)].
2. Data Certification:  
Pursuant to 42 CFR 438.604 and 42 CFR 438.606, MCOPs are required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to ODM which may affect MCOP payment.
- a. MCOP Submissions: MCOPs must submit the appropriate ODM-developed certification concurrently with the submission of the following data or documents:
    - i. Encounter Data [as specified in the Data Quality Appendix (Appendix L)]
    - ii. Prompt Pay Reports [as specified in the Fiscal Performance Appendix (Appendix J)]
    - iii. Cost Reports [as specified in the Fiscal Performance Appendix (Appendix J)]
    - iv. Care Management Data [as specified in the Data Quality Appendix (Appendix L)]
    - v. HEDIS IDSS Data/FAR [as specified in the Data Quality Appendix (Appendix L)]

- b. Source of Certification: The above MCOP data submissions must be certified by one of the following:
- i. The MCOP's Chief Executive Officer;
  - ii. The MCOP's Chief Financial Officer,
  - iii. An individual who has delegated authority to sign for, and who reports directly to, the MCOP's Chief Executive Officer or Chief Financial Officer.

MCOPs must provide certification as to the accuracy, completeness, and truthfulness of additional submissions.

3. Pursuant to 42 CFR 455.20, MCOPs must have a method for verifying with enrollees whether services billed by providers were received. Therefore, the MCOP is required to conduct a mailing of Explanation of Benefits (EOBs) to a 95% confidence level (plus or minus 5 percent margin of error) random sample of the MCOP's enrollees once a year. As an option, the MCOP may meet this requirement by using a strategy targeting services or areas of concern as long as they number of mailed EOBs is no less than the number generated by the random sample described above. Any MCOP opting to use a targeted mailing must submit the proposed strategy in writing to ODM, and receive written prior approval from ODM. The EOB mailing must only include those members that have received health care services within the last six months, comply with all state and federal regulations regarding release of personal health information, outline the recent medical services identified as having been provided to the enrollee, and request that the enrollee report any discrepancies to the MCOP. The MCOP must inform its Contract Administrator of the date of the EOB mailing and provide results of the mailing 60 to 90 days after the mailing (i.e., number mailed, number of enrollees reporting discrepancies).
4. Breaches of Protected Health Information: The MCOP must report the number of breaches of protected health information (PHI) and specify how many breaches were reported to HHS as required by 45 CFR Part 164.408 (b) and (c). This report must be submitted annually as indicated on the "MCOP Calendar of Required Submissions."
5. Waiver Integrity Reporting Requirements  
The MCOP must perform unit of service /claims validation for waiver services claims in accordance with Ohio's approved 1915(c) waiver, and must respond promptly to requests for claims verification in support of Provider Certification and Structural Compliance processes administered by ODM, ODA or their designee.

In accordance with ODM's 1915(c) CMS-approved waiver, the MCOP must report the following information to ODM:

- a. Waiver Service Claims Audit: In accordance with ODM's 1915(c) CMS-approved waiver, the MCOP must report semi-annually (January 31 and July 31) or as requested by

- ODM the number and percent of waiver services claims that have been verified through a review of provider documentation to have been paid in accordance with individuals' waiver service plans. The MCOP must review a representative sample stratified by waiver service type, with a confidence interval of 95% with a margin of error of +/- 5%.
- b. The MCOP must report semi-annually (January 31 and July 31) or as requested by ODM the number and percent of claims identified in a., above, for which the MCOP recovered payment. The first report is required to be submitted to ODM on July 31, 2015. That report must include verifications that cover the entire period back to the MCOP's MyCare Ohio start-up date.
  - c. The MCOP must report the number of providers and members affected in regards to sub-paragraphs a. and b. above. This information is also due on January 31 and July 31.
  - d. Copy of Annual Audit to ODM: The MCOP must submit to ODM on an annual basis (July 31) a copy of its independently audited annual financial reports. These annual financial reports must be audited in accordance with Generally Accepted Auditing Standards by an independent certified public accountant.

## **APPENDIX J**

### **FINANCIAL PERFORMANCE FOR MYCARE OHIO PLANS**

Pursuant to Section 2.13, Financial Requirements, of the Three-Way Contract, MyCare Ohio Plans (MCOPs) must adhere to the financial measures, standards and reporting requirements contained therein. In addition, MCOPs must adhere to the prompt pay standards set forth in Section 5.1.9.1 of the Three-Way Contract.

Annual and quarterly cost reports must be revised in accordance with the actuaries' observation log or as otherwise instructed by ODM.

## APPENDIX K

### QUALITY CARE

This appendix establishes program requirements and expectations related to the MyCare Ohio Plan's (MCOP's) responsibilities for developing and implementing a care delivery model, which includes the establishment of a primary care provider for individuals; health promotion and wellness activities; a care management program; and utilization management programs. The MCOP must also develop Quality Assessment and Performance Improvement programs and participate in external quality review activities. These program requirements are applicable to dual benefits (also referred to as "opt in") members and Medicaid only (also referred to as "opt out) members and support the priorities and goals set forth in the Ohio Medicaid Quality Strategy.

#### 1. Care Delivery Model

- a. Primary care: In accordance with the Three-Way Contract between MCOP, CMS and ODM (the Three-Way), Section 2.5.1, the MCOP is required to ensure that each Medicaid only member has a primary care provider who will serve as an ongoing source of primary and preventive care and will perform care coordination activities appropriate to the member's needs.
- b. Health promotion and wellness activities: In accordance with the Three-Way, Section 2.5.2, each MCOP must develop and offer a range of health and wellness programs and informational material that target specific health needs and risk behaviors identified for the MCOP's membership.
- c. Direct access to specialists: In accordance with the Three-Way, Section 2.6.1.16, the MCOP must implement a provision for members, specifically those with special health care needs, to directly access a specialist (e.g., for an approved number of visits or a standing referral) as appropriate for the member's condition and health care needs. The MCOP must inform members of their right to directly access a specialist.
- d. Utilization management programs: In accordance with the Three-Way, Sections 2.4 and 2.8, and Ohio Administrative Code (OAC) 5160-58-01.1 and 5160-26-03.1(A)(7), the MCOP must implement utilization management programs with clearly defined structures and processes to maximize the effectiveness of the care provided to dual benefits and Medicaid only members.
  - i. Drug Utilization Management Programs: The MCOP may, pursuant to ORC Sec. 5167.12 implement strategies for the management of drug utilization for Medicaid covered drugs that are not covered by Medicare Part D. The MCOP may, subject to ODM prior approval, require prior authorization of certain drug classes and place limitations on the type of provide and locations where certain drugs may be administered. The MCOP must establish its PA system so that it does not necessary impede

member access to medically-necessary Medicaid covered services. The MCOP must comply with the provisions of OAC 5160-58-01.1 regarding the timeframes for prior authorization of covered outpatient drugs.

- ii. For Medicaid covered nursing facility stays, the MCOP must evaluate the member's need for the level of services provided by a nursing facility. To make this decision, the MCOP must use the criteria for nursing facility-based level of care pursuant to OAC rules 5160-3-08 and 5160-1-01. The MCOP must maintain a written record that the criteria were met, or if not met, the MCOP must maintain documentation that a Notice of Action was issued in accordance with OAC 5160-58-08.4.
- iii. Nursing Facility Level of Care Determinations - Pursuant to Section 2.5.3.3.5.2 of the Three-Way, the MCOP must request Level of Care determinations from the local Area Agencies on Aging except in the case of nursing facility stays for which level of care authority is delegated to the MCOP.
- e. The MCOP must utilize ongoing medication reconciliation, employment of advanced practice pharmacy management programs, including medication therapy management, and in-person pharmacy consultation to increase adherence to medication regimens and eliminate contra-indicated drugs.
- f. Transitions of Care - The MCOP must effectively and comprehensively manage transitions of care between settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The MCOP must at a minimum:
  - i. Identify members who require assistance transitioning between care settings;
  - ii. Develop a method for evaluating risk of readmission in order to determine the intensity and urgency of follow up that is required for the member after the date of discharge;
  - iii. Designate MCOP staff who will regularly communicate with the discharging facility and inform the facility of the designated MCOP contacts;
  - iv. Ensure that timely notification and receipt of admission dates, discharge dates and clinical information is communicated between internal MCOP departments and between care settings, as appropriate;

- v. Participate in discharge planning activities with the facility including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCOP;
- vi. Obtain a copy of the discharge/transition plan;
- vii. Arrange for services specified in the discharge/transition plan;
- viii. Conduct timely follow up with the member and member's providers to ensure post discharge services have been provided.

When an MCOP is contacted by an inpatient facility for the MCOP's member, who is not identified in 1.f.a and 1.f.b, with a request for assistance with discharge planning, the MCOP must initiate and implement steps 1.f.c – h, as applicable, to ensure adequate discharge planning occurs for the member.

The MCOP must ensure that the transition/discharge plan and post-discharge services are integrated into the member's care plan. Upon request, the MCOP may be required to submit the transition of care strategy as prescribed by ODM for approval.

g. Care Management:

- i. Care Management Program Requirements: Pursuant to the Three-Way, Section 2.5.3, the MCOP must provide care management services to all members, including dual benefits and Medicaid only. In addition, the MCOP must also adhere to the following requirements:
  - a. For Medicaid only members, the MCOP shall coordinate with any *Medicare Advantage* Plan that is the primary payor of Medicare services, if applicable, in an effort to reduce gaps or duplication of services.
  - b. The MCOP must also adhere to all operational standards articulated in the approved Ohio Home and Community Based Services 1915(c) waiver for MyCare Ohio.
  - c. The MCOP is not required to conduct a new initial comprehensive assessment or annual reassessment if an assessment or reassessment was previously conducted by the current or prior MCOP and one of the following conditions apply:

- i. A member remains enrolled with the MCOP; or
- ii. A member was previously enrolled with the current MCOP in the prior 90 calendar days; or
- iii. A member had an assessment completed with a prior MCOP and the assessment was transferred from the disenrolling MCOP to the enrolling MCOP per Appendix C.

Updates to the initial assessment must comply with Section 2.5.3.2.3.7 of the Three-Way agreement.

- d. Sanctions for non-compliance with care management and waiver procedural requirements are identified in Appendix N of this Provider Agreement.
- ii. Care Management Staffing ratio: ODM will assess MCOP compliance with the staffing ratios established in the Three-Way, Section 2.5.3.3.1.3, and as specified in the *ODM Methods for the My Care Ohio Care Management Staffing Ratio*. The staffing ratio is defined as one full time equivalent (FTE) per the number of dual benefits and Medicaid only members specified for each risk stratification level below. The staffing ratios must fall within the performance standard ranges for each risk stratification level as specified below:

Risk Stratification Level	Staffing Ratio	Performance Standard
Intensive	1:25 – 1:50	≥.0200
High	1:51 – 1:75	.0196 - .0133
Medium	1:76 – 1:100	.0132 - .0100
Low	1:101 – 1:250	.0099 - .0040
Monitoring	1:251 – 1:350	.00398 and 0029

The staffing ratios will be calculated semiannually for the following measurement periods: July 2014 – December 2014; January 2015 – June 2015; July 2015 – December 2015; January 2016 – June 2016; July 2016 – December 2016; January 2017 – June 2017; and July 2017 – December 2017.

The sanctions for non-compliance with the minimum performance standards are listed in Appendix N of this Provider Agreement.

- iii. The MCOP must employ a methodology for assigning consistent and appropriate caseloads for care managers that assures health, welfare and

safety for members. The MCOP must incorporate the following factors into its caseload assignment methodology:

- population;
- acuity status mix;
- care manager qualifications, years of experience, and responsibilities;
- provision of support staff; location of care manager (community, MCOP office, provider office);
- geographic proximity of care manager to members (if community based); and
- access to and capabilities of technology/IT systems.

The MCOP must ensure there is a method to periodically evaluate caseload assignments, including identification of circumstances that automatically trigger a review or adjustment of caseload sizes. The MCOP must submit a description of the methodology to ODM as specified and when requested.

- iv. Comprehensive assessment measures: The MCOP must complete an initial comprehensive assessment and an annual reassessment of medical, behavioral, LTSS and social needs for each MyCare beneficiary as specified in Section 2.5.3.2.3 of the Three-Way Agreement. ODM will assess MCOP compliance with these requirements by using results from the following measures:
- a. Initial comprehensive assessment:
1. *Measure*: The percent of members enrolled in the MCOP who received an initial comprehensive assessment within 90 days of the enrollment effective date.
  2. *Measurement periods*: January – March 2015; April – June 2015; July – September 2015; October – December 2015, January – March 2016, April – June 2016, July – September 2016, October – December 2016, January – March 2017, April – June 2017.
  3. *Minimum Performance Standard*: Less than 10 percentage points below the percentage achieved by the highest performing MCOP during the measurement period.
- b. Annual reassessment:
1. *Measure*: The percent of members enrolled in the MCOP who received an annual reassessment within 365 days of the initial comprehensive assessment completion date.
  2. *Measurement periods*: July – September 2015; October – December 2015; January – March 2016, April – June 2016, July – September 2016, October – December 2016, January – March 2017, April – June 2017.

3. *Minimum Performance Standard:* Less than 10 percentage points below the percentage achieved by the highest performing MCOP during the measurement period.

The sanctions for non-compliance with the minimum performance standards are listed in Appendix N of this Provider Agreement.

- v. Measures and measurement periods and compliance determination:

ODM reserves the right to revise the measures and measurement periods established in this appendix (and their corresponding periods), as needed due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCOP's performance level for that contract period.

In the event an MCOP's performance cannot be evaluated for a care management program evaluation measure and measurement period established in this appendix, ODM in its sole discretion will deem the MCOP to have met or to have not the standard(s) for that particular measure and measurement period depending on the circumstances involved.

- vi. HCBS Waiver operational reporting requirements:

- a. The MCOP must report the following to ODM on the 15th of July, October, January and April of each calendar year:
  - i. Total number of individuals who have a risk agreement by the following categories: drug/alcohol issues, unsafe smoking, and non-compliance with healthcare.
  - ii. Total number of individuals with behavior support plans by category: mechanical restraints, chemical restraints, physical, seclusion, and restrictive interventions.
  - iii. Total number of behavior support plans by category as indicated in g.v.a.ii by authorizing entity: physician, psychologist, county board of developmental disabilities, and other behavioral health professional.
  - iv. Total number of individuals with behavior support plans reported in g.v.a.ii for which the MCOP activated the behavioral support plan with an indication of the used restraint or seclusion.
  - v. Total number of individuals with behavior support plans reported in g.v.a.ii for which the MCOP activated the behavioral support plan with an indication of the restrictive intervention used.

- b. In the event that the MCOP activates the Emergency Response Plan (ERP) pursuant to the Three-Way, Section 2.5.3.3.5.4.6, the MCOP must document the outcomes of the ERP and submit to ODM when requested.

Sanctions for non-compliance with these requirements are listed in Appendix N of this Provider Agreement.

- h. Specialized Recovery Services (SRS) Program - Beneficiaries who are eligible to receive Specialized Recovery Services (i.e., recovery management, peer recovery support and individualized placement and support – supported employment), will be assigned a recovery manager by ODM who will perform assessments, person-centered planning, and coordination of SRS. Recovery managers will be employed by an Independent Entity, an existing Ohio Home Care case management agency contracted with ODM. As such, the MCOP is not permitted to perform recovery management services and must contract with at least one Independent Entity in the MyCare Ohio service area.

The MCOP is responsible for the payment of SRS. The MCOP must allow beneficiaries to maintain current service levels at the time of enrollment for at least 180 days after the initial enrollment effective date with the MCOP. After a beneficiary's transition period concludes, the MCOP may prior authorize SRS in accordance with 42 CFR 438.210.

The MCOP will include the recovery manager as part of the beneficiary's MyCare Ohio care management team. The SRS person-centered care plan will be integrated into the beneficiary's comprehensive care plan. The MCOP's care manager will adhere to ODM's incident management rule specified in 5160-58-05.3 for beneficiaries receiving SRS. If an incident is reported to the MyCare care manager for a beneficiary receiving SRS, the care manager must inform the recovery manager. Prevention plans will be jointly developed by the MCOP care manager and the recovery manager.

The MCOP will refer a beneficiary who is potentially eligible for SRS to its contracted Independent Entity to initiate the SRS eligibility determination process.

## 2. Quality Assessment and Performance Improvement Program

- a. Each MCOP must implement a Quality Assessment and Performance Improvement (QAPI) program in accordance with the Three-Way, Sections 2.11 that applies to both the dual benefits and Medicaid-only populations.
- b. Each MCOP must develop and implement Performance Improvement Projects (PIP) pursuant to the Three-Way, Section 2.11.3.4. Topics will be selected by ODM. The MCOP must adhere to ODM PIP format, content specifications and timelines for PIP implementation and reporting. All PIP submissions will be reviewed and approved by ODM and CMS. The MCOP must submit the results of each PIP to ODM annually; however, ODM reserves the right to require that MCOPs provide status updates no more frequent than monthly to ODM. The EQRO will assist MCOPs with the development

and implementation of PIPs by providing technical assistance and will annually validate the PIPs.

Initiation of PIPs will begin in the 4<sup>th</sup> quarter of 2014. No more than two PIPs will be in an active status per calendar year.

The MCOP shall actively participate in PIPs facilitated by ODM or the EQRO, or both. This includes but is not limited to:

- Attending meetings;
- Assigning MCOP staff to the PIP efforts who are subject matter experts in the PIP topic, are familiar with MCOP policies and processes related to the topic, have been trained in quality improvement science and rapid cycle quality improvement approaches, and who have decision making authority;
- Responding promptly to data and information requests;
- Dedicating resources to test and implement quality improvement interventions;
- Establishing internal mechanisms to frequently communicate PIP status updates and results to the MCOP's Medical Director or Quality Improvement Director; and
- Maintaining regular communication with ODM or EQRO staff.

MCOP Medical Directors, Quality Improvement Directors, and at least one MCOP staff assigned to PIP/QIP teams will be required to complete coursework in the application of rapid cycle quality improvement science tools and methods from an ODM approved entity.

Content should include topics such as:

- The Model for Improvement<sup>1</sup> developed by the Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI)
- Edward W. Deming's System of Profound Knowledge
- Listening to and incorporating the Voice of the Customer (VOC)
- Process mapping/flow charting
- SMART Aim development and the use of key driver diagrams<sup>1</sup> for building testable hypotheses
- Methods for barrier identification and intervention selection (e.g., root cause analyses, Pareto charts, failure mode and effects analysis, the 5 why technique)
- Selection and use of process, outcome and balancing measures
- Testing change through the use of PDS(C)A cycles<sup>2</sup>
- The use of statistical process control, such as the Shewart control chart<sup>3</sup>
- Tools for spread and sustainability planning

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<sup>1</sup>Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

<sup>2</sup> Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000

<sup>3</sup> Revelle JB. *Quality Essentials: A Reference Guide from A to Z*, ASQ Quality Press, 2004.

Examples of approved entities offering coaching and/or training in these areas include: the Institute for Healthcare Improvement, the Intermountain Healthcare leadership, the Cincinnati Children's Hospital Anderson Center for Health System Excellence, Institute the American Society for Quality's learning Institute, the Deming Institute, and the National Association for Healthcare Quality.

Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, along with QI Directors and at least one MCOP staff person involved in each ODM initiated QIP/PIP must submit training curricula to ODM for approval prior to enrollment. Evidence of course completion must be submitted by June 30, 2017. Staff will be exempt from this requirement if one of the following conditions is met: 1) an accredited/certified education course in quality improvement science has been completed since July 1, 2014; or 2) satisfactory completion of NCQA CPHQ or ASQ CQIA certification after January 1, 2015. Medical Directors with a substantial role in improvement projects or who are accountable for the QAPI program, as well as Quality Improvement Directors hired after July 1, 2016, must complete the course within six months of the start date unless they have evidence of course completion within the two years prior to their effective start date.

The MCOP shall integrate results from performance improvement projects into its overall quality assessment and performance improvement program.

c. Quality Measurement Assessment and Improvement Strategy

The MCOP must measure, analyze, and track performance indicators which reflect Ohio Medicaid's Quality Strategy clinical focus areas (e.g., behavioral health) and other quality initiatives in place to advance the goals of the Quality Strategy. The MCOP must include all measures listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* and may also include other measures (e.g., the full NCQA accreditation set) that assist the MCOP in advancing the goals of the Quality Strategy and the Duals Demonstration Project.

The MCOP's quality measurement assessment and improvement strategy must include the following activities:

- i. Establishing a measureable goal and benchmark for each performance indicator;
- ii. Measuring performance and comparing the rate for each indicator to the established goal and benchmark (baseline);
- iii. Reviewing data trends to detect improvement, decline or stability in the rates at a frequency no less often than quarterly;
- iv. Identifying opportunities for improvement;

- v. Conducting a root cause analysis to identify factors that may impact the adequacy of rates;
- vi. Developing and quality improvement interventions, using a rapid cycle improvement approach, that will address the root cause of the deficiency; and
- vii. Developing a plan to monitor the quality improvement interventions to detect if the changes are an improvement.

The MCOP must ensure that these activities are linked to the MCOP's annual evaluation of the impact and effectiveness of its quality program. Upon request, the MCOP must make the performance indicator tracking and reporting mechanisms available for review by ODM. Annual QAPI submissions are due on or before November 15th.

### 3. External Quality Review

The MCOP must participate in annual external quality review activities as specified in OAC rules 5160-58-01.1 and 5160-26-07.

The review will include but not be limited to the following activities:

3.a. Administrative compliance assessment as required by 42 CFR 438.358 and as specified by ODM.

3.a.i. Non duplication exemption – As allowed by 42 CFR 438.360 and 438.362, an MCOP with accreditation from a national organization approved by the Centers for Medicare and Medicaid services may request to be exempted from certain portions of the administrative compliance assessment. ODM will inform the MCOP when a non-duplication exemption may be requested.

3.a.ii. The EQRO may conduct focused reviews of MCOP performance in the following domains which include, but are not limited to:

1. Availability of services
2. Assurance of adequate capacity and services
3. Coordination and continuity of care
4. Coverage and authorization of services
5. Credentialing and re-credentialing of services
6. Sub contractual relationships and delegation
7. Enrollee information and enrollee rights
8. Confidentiality of health information
9. Enrollment and disenrollment
10. Grievance process
11. Practice guidelines
12. Quality assessment and performance improvement program
13. Health information systems
14. Fraud and abuse

3.b. Encounter data studies

- 3.c. Validation of performance measurement data
- 3.d. Review of information systems
- 3.e. Validation of performance improvement projects
- 3.f. Member satisfaction and/or quality of life surveys

The sanctions for non-compliance with external quality review activities are listed in the Appendix N of this Provider Agreement

## **APPENDIX L**

### **DATA QUALITY**

A high level of performance on the data quality standards and requirements established in this appendix is crucial in order for the Ohio Department of Medicaid (ODM) to determine the value of the MyCare Ohio Program and to evaluate MyCare Ohio members' access to and quality of services. Encounter data collected from MyCare Ohio Plans (MCOPs) are used in key performance assessments, such as: the external quality review, clinical performance measures, utilization review, care coordination and care management, and in determining quality withholds. The data will also be used in conjunction with the cost reports in setting the capitation rates. The Encounter Data Volume measures, as specified in this appendix, will be calculated separately per MCOP for the dual benefit members (opt-in population) and those Medicaid-only members (opt-out population) and include all MyCare Ohio members receiving services from the MCOP per these two populations. These measures will be calculated separately for Medicaid and Medicare services for the dual benefit members (opt-in population) and only for the Medicaid services for the Medicaid-only members (opt-out population). All other encounter data quality measures, as specified in this Appendix, will be calculated for each MCOP: Rejected Encounters, Acceptance Rate, Encounter Data Accuracy Study measure (Payment Accuracy), Incomplete Rendering Provider Data, NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers, and Timeliness of Encounter Data Submission.

ODM reserves the right to revise the measures and report periods established in this appendix (and their corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCOP's performance level for that contract period.

#### **1. ENCOUNTER DATA**

For detailed descriptions of the encounter data quality measures below, see *ODM Methods for the MyCare Ohio Encounter Data Quality Measures*.

Each MCOP's encounter data submissions will be assessed for completeness and accuracy per Section 2 of the Three-Way Contract between MCOP, Centers for Medicare and Medicaid Services (CMS) and ODM (Three-Way),. The MCOP is responsible for collecting information from providers and reporting the data to ODM in accordance with program requirements established in Appendix C, *MCOP Responsibilities*. Failure to do so jeopardizes the MCOP's ability to demonstrate compliance with other performance standards.

##### **1.a. Encounter Data Completeness**

###### **1.a.i. Encounter Data Volume**

*Measure:* The volume measure for each service category, as listed in the tables below, is the rate of utilization (e.g., discharges, visits) per 1,000 member months (MM).

*Report Period:* The report periods for Calendar Year (CY) 2014 through CY 2017 contract periods are listed in Table 1 below. Fee-For-Service (FFS) Medicaid data will be used as a baseline to set interim data quality standards for Medicaid services for CY 2014 and the first two quarters of CY 2015. Data quality standards for Medicare services and updated data quality standards for Medicaid services will be determined after ODM has collected Medicaid and Medicare encounter data from the MCOPs for at least two quarters. This measure will be used for informational purposes only until February 2017. Beginning in February 2017, this measure will be used to determine compliance.

**Table 1. Report Periods for the CY 2014 - CY 2017 Contract Periods**

MCOP Quarterly Report Periods	Data Source (Estimated Encounter Data File Update)	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1 2014 - Not Applicable	TBD	TBD	CY 2014
Qtr 2: 2014	TBD	TBD	
Qtr 2 and Qtr 3: 2014	TBD	TBD	
Qtr 2 thru Qtr 4:2014	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 2015	TBD	TBD	CY 2015
Qtr 2 thru Qtr 4: 2014; Qtr 1, Qtr 2: 2015	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 3: 2015	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 2016	TBD	TBD	CY 2016
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1, Qtr 2: 2016	TBD	TBD	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru Qtr 3: 2016	January 2017	February 2017	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru Qtr 4: 2016	April 2017	May 2017	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru Qtr 4: 2016; Qtr 1 2017	July 2017	August 2017	CY 2017
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru Qtr 4: 2016; Qtr 1, Qtr 2: 2017	October 2017	November 2017	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru Qtr 4: 2016; Qtr 1 thru Qtr 3: 2017	January 2018	February 2018	
Qtr 2 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015; Qtr 1 thru Qtr 4: 2016; Qtr 1 thru Qtr 4: 2017	April 2018	May 2018	

Qtr1 = January to March; Qtr2 = April to June; Qtr3 = July to September; Qtr 4 = October to December

The dual benefit member (opt-in population) data quality standards for the encounter data volume measure for Medicaid and Medicare services are listed in Tables 2. and 3. below, respectively. The MCOP’s utilization rate for each service category listed in Tables 2. and 3. must be equal to or greater than the associated standard established for each service category in Tables 2 and 3, in all quarters of the measurement period.

**Table 2. Dual Benefit Members (Opt-In Population) Medicaid Services Standards – Encounter Data Volume**

Category	Measure per 1,000/MM	Standard	Description
Inpatient Hospital	Discharges	TBD	General/acute care, excluding newborns and mental health and chemical dependency services
Nursing Facility	Claims	TBD	Nursing facility monthly claims
Emergency Department	Visits	TBD	Includes physician and hospital emergency department encounters
Dental		TBD	Non-institutional and hospital dental visits
Vision		TBD	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		TBD	Physician/practitioner and hospital outpatient visits
Behavioral Health	Service	TBD	Inpatient and outpatient behavioral encounters
Waiver		TBD	Professional Waiver services
Pharmacy	Prescriptions	TBD	Prescribed drugs

**Table 3. Dual Benefit Members (Opt-In Population) Medicare Services Standards – Encounter Data Volume**

Category	Measure per 1,000/MM	Standard	Description
Inpatient Hospital	Discharges	TBD	General/acute care, excluding newborns and mental health and chemical dependency services
Nursing Facility	Claims	TBD	Nursing facility monthly claims
Emergency Department	Visits	TBD	Includes physician and hospital emergency department encounters
Primary and Specialist Care		TBD	Physician/practitioner and hospital outpatient visits
Behavioral Health	Service	TBD	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	TBD	Prescribed drugs

The Medicaid-only member (opt-out population) data quality standards for the encounter data volume measure for Medicaid services are listed in Table 4. below. The MCOP’s utilization rate for each service category listed in Table 4. must be equal to or greater than the associated standard established for each service category in Table 4, in all quarters of the measurement period.

**Table 4. Medicaid-only (Opt-Out Population) Medicaid Service Standards – Encounter Data Volume**

Category	Measure per 1,000/MM	Standard	Description
Inpatient Hospital	Discharges	TBD	General/acute care, excluding newborns and mental health and chemical dependency services
Nursing Facility	Claims	TBD	Nursing facility monthly claims
Emergency Department	Visits	TBD	Includes physician and hospital emergency department encounters
Dental		TBD	Non-institutional and hospital dental visits
Vision		TBD	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		TBD	Physician/practitioner and hospital outpatient visits
Behavioral Health	Service	TBD	Inpatient and outpatient behavioral encounters
Waiver		TBD	Professional Waiver services
Pharmacy	Prescriptions	TBD	Prescribed drugs

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

**1.a.ii. Incomplete Rendering Provider Data**

This measure is calculated per MCOP and includes all Ohio MCOP members receiving services from the MCOP. The *Incomplete Rendering Provider Data* measure is calculated to ensure that MCOPs are reporting individual-level rendering provider information to ODM, so that ODM complies with federal reporting requirements. *Measure:* The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in the Medicaid Information Technology System (MITS).

*Report Period:*

The report periods for CY 2014 through CY 2017 contract periods are listed in Table 1 above. Results for CY 2014 will be informational (reporting only). CY 2014 will be used as a baseline to set interim performance standards for CY 2015. Q1 and Q2 of CY 2015 will be used as a baseline to set performance standards for CY 2017, with additional updates to be determined based on data submitted throughout CY 2015 through CY 2017. MCOPs must meet or exceed the standard in all quarters of the report period. This measure will be used for informational purposes only until February 2017. Beginning in February 2017, this measure will be used to determine compliance.

*Data Quality Standard:* TBD

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

**1.a.iii. NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers**

This measure is calculated per MCOP and includes all Ohio MCOP members receiving services from the MCOP. The *NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers* measure is calculated to ensure that providers reported on encounters can be associated with Medicaid and/or Reporting providers in MITS.

*Measure:* The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data field that do not have a Medicaid or Reporting Provider Number in MITS.

*Report Period:*

The report periods for CY 2014 through CY 2017 contract periods are listed in Table 1 above. Results for CY 2014 will be informational (reporting only). CY 2014 will be used as a baseline to set interim performance standards for CY 2015. Q1 and Q2 of CY 2015 will be used as a baseline to set performance standards for CY 2017, with additional updates to be determined based on data submitted throughout CY 2015 through CY 2017. MCOPs must meet or exceed the standard in all quarters of the report period. This measure will be used for informational purposes only until February 2017. Beginning in February 2017, this measure will be used to determine compliance.

*Data Quality Standard:* TBD

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

#### **1.a.iv. Rejected Encounters**

Encounters submitted to ODM that are incomplete or inaccurate are rejected and reported back to the MCOPs on the Exception Report. If an MCOP does not resubmit rejected encounters, ODM's encounter data set will be incomplete; therefore, MCOP shall resubmit the required data within the period of time specified by ODM.

These measures are calculated per MCOP and include all Ohio MCOP members receiving services from the MCOP.

#### **1) Measure 1 - Measure 1 only applies to MCOPs that have had MCOP membership for more than one year.**

*Measure 1:* The percentage of encounters submitted to ODM that are rejected

*Report Period:* Results for CY 2014 will be informational (reporting only). CY 2014 data will be used as a baseline to set data quality standards for CY 2015. For CY 2015 through CY 2017, the report periods will be quarterly. This measure will be used for informational purposes only until February 2017. Beginning in February 2017, this measure will be used to determine compliance.

*Data Quality Standard for measure 1:* The data quality standard for measure 1 is TBD for each file type in the ODM-specified medium per format.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

#### **2) Measure 2 - Measure 2 only applies to MCOPs that have had MCOP membership for one year or less.**

*Measure 2:* The percentage of encounters submitted to ODM that are rejected.

*Report Period:* Results for CY 2014 will be informational (reporting only). CY 2014 data will be used as a baseline to set data quality standards for CY 2015. The report period for Measure 2 is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

*Data Quality Standard for measure 2:* The data quality standard for measure 2 is a maximum encounter data rejection rate for each file type in the ODM-specified medium per format as follows:

Third through sixth month with MCOP membership: Not applicable for SFY 2017

Seventh through twelfth month with MCOP membership: Not applicable for SFY 2017

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

### **1.a.v. Acceptance Rate**

**This measure only applies to MCOPs that have had MCOP membership for one year or less.**

*Measure:* The rate of encounters that are submitted to ODM and accepted (i.e. accepted encounters per 1,000 member months).

*Measurement Period:* The measurement period for this measure is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

*Data Quality Standard:* The data quality standard is a monthly minimum accepted rate of encounters for each file type in the ODM-specified medium per format as follows:

Third through sixth month with membership: Not Applicable for SFY 2017

Seventh through twelfth month of membership: Not Applicable for SFY 2017

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with the standards for this measure.

### **1.b. Encounter Data Accuracy**

As with data completeness, MCOPs are responsible for assuring the collection and submission of accurate data to ODM. Failure to do so jeopardizes MCOPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

#### **1.b.i. Encounter Data Accuracy Study**

*Measure:* This accuracy study will compare the accuracy and completeness of payment data stored in MCOPs' claims systems during the study period to payment data submitted to and accepted by ODM. The measure will be calculated per MCOP. Two levels of analysis will be conducted: one to evaluate encounter data completeness for which two rates will be calculated and one to evaluate payment data accuracy. Payment completeness and accuracy rates will be determined by aggregating data across claim types (i.e., professional, pharmacy, and institutional) and stratifying data by file type (i.e., header and detail). At a minimum, the additional components of analysis will include diagnosis codes and provider information (e.g., rendering provider, billing provider).

Encounter Data Completeness (Level 1):

Omission Encounter Rate: The percentage of encounters in an MCOP's fully adjudicated claims file not present in the ODM encounter data files.

Surplus Encounter Rate: The percentage of encounters in the ODM encounter data files not present in an MCOP's fully adjudicated claims files.

Payment Data Accuracy (Level 2):

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**Payment Error Rate:** The percentage of matched encounters between the ODM encounter data files and an MCOP's fully adjudicated claims files where a payment amount discrepancy was identified.

*Report Period:* In order to provide timely feedback on the omission rate of encounters, the report period will be the most recent from when the study is initiated. This study is conducted annually.

*Data Quality Standards:*

For CY 2015:

For Level 1: An omission encounter rate and a surplus encounter rate of no more than 11% for both claim-level and line-level records.

For Level 2: A payment error rate of no more than 4%.

For CY 2016:

For Level 1: An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.

For Level 2: A payment error rate of no more than TBD.

For CY 2017:

For Level 1: An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.

For Level 2: A payment error rate of no more than TBD.

For CY 2018:

For Level 1: An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.

For Level 2: A payment error rate of no more than TBD.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standards for this measure.

### **1.c. Encounter Data Submission**

Information concerning the proper submission of encounter data may be obtained from the *ODM ICDS Encounter Data Submission Specifications* document. Note: the *ODM MyCare Ohio Encounter Data Submission Specifications* include: encounter data companion guides for institutional, professional, and dental 837 EDI transactions; NCPDP D.0 files; 824 EDI response transactions; U277 EDI response transactions; *ODM MyCare Ohio Encounter Data Submission Guidelines*; *ODM MyCare Ohio Encounter Data Submission Schedule*; and *Encounter Data Letter of Certification*. The encounter data companion guides must be used in conjunction with the X12 Implementation Guide for EDI transactions.

### **1.c.i. Encounter Data Submission Procedure**

The MCOP must submit encounter data files to ODM per the specified schedule and within the allotted amount established in the *ODM MyCare Ohio Encounter Data Submission Specifications*.

The MCOP must submit a letter of certification, using the form required by ODM, with each encounter data file in the ODM-specified medium per format.

The letter of certification must be signed by the MCOP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCOP's CEO or CFO (see *ODM MyCare Ohio Encounter Data Submission Specifications*).

See Appendix N of this Provider Agreement for the sanctions for noncompliance with these data submission requirements.

### **1.c.ii. Timeliness of Encounter Data Submission**

ODM recommends submitting MCOP-paid encounters no later than thirty-five days after the end of the month in which they were paid. ODM currently monitors minimum encounter data claims volume (Section 1.a.i.) and rejected encounters (Section 1.a.iv.) and the standards for these measures are based on encounters being submitted within this time frame. Beginning in March 2015 for claims paid in January 2015, MCOPs must report on encounter data submission lag time on a monthly basis to ODM. Results may be subject to an audit by ODM and/or a vendor representing ODM.

Effective SFY 2016 (July 2015), ODM will evaluate the timeliness of MCOP encounter data submissions.

*Measure:* The percentage of encounters that are submitted to ODM and accepted within 60 calendar days of the month in which they were paid. (e.g., claims paid by the MCOP in January 2015 would be reported after April 2, 2015).

*Measurement Periods:* TBD

*Data Quality Standard:* (effective SFY 2016) TBD

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standard for this measure.

### **1.c.iii. Encounter Submissions Per Encounter Schedule**

*Measure:* The percent of encounters listed on the Encounter Data Submission Schedule as the minimum amount for that month that were submitted to ODM and accepted.

*Measurement Periods:* TBD

*Data Quality Standard:* The data quality standard is greater than or equal to 100%.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standard for this measure.

## **2. MCOP SELF-REPORTED, AUDITED HEDIS DATA**

### **2.a. Annual Submission of HEDIS IDSS Data**

The MCOP is required to collect, report, and submit to ODM self-reported, audited HEDIS data for the full set of HEDIS measures reported by the MCOP to NCQA for MyCare Ohio members per *ODM's Specifications for the Collection and Submission of MyCare Ohio Self-Reported, Audited HEDIS Results*. The self-reported, audited HEDIS data are due to ODM no later than five business days after the NCQA due date.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with this data submission requirement.

### **2.b. Annual Submission of Final HEDIS Audit Report (FAR)**

The MCOP is required to submit to ODM its FAR that contains the audited results for the full set of HEDIS measures reported by the MCOP to NCQA for MyCare Ohio members. This must include all HEDIS measures referenced in Appendix M. The FAR is due to ODM no later than five business days after the NCQA due date.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with this data submission requirement.

Note: ODM will review each MCOP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. ODM reserves the right to pursue corrective action based on this review (see Appendix N of this Provider Agreement).

### **2.c. Data Certification Requirements for HEDIS IDSS Data and Final HEDIS Audit Report**

In accordance with 42 CFR 438.600, *et seq.*, each MCOP must submit a signed data certification letter to ODM attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODM. Each MCOP must also submit to ODM a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODM.

Each data certification letter is due to ODM on the same days that the respective HEDIS IDSS data/FAR are submitted to ODM. Additional specifications regarding the data certification letters will be made available in future technical guidance.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with these data submission requirements.

### **3. CARE MANAGEMENT DATA**

The MCOP must submit care management data in accordance with the *MyCare Ohio Care Management Data Submission Specifications*.

In accordance with 42 CFR 438.600—438.606, each MCOP must submit the ODM required signed data certification letter to ODM attesting to the accuracy and completeness of care management data submitted to ODM.

Care management data files and the data certification letters are due on the 10th calendar day of each month.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with these data submission requirements.

### **4. APPEALS AND GRIEVANCES DATA**

Pursuant to OAC rule 5160-58-08.4, the MCOP is required to submit appeal and grievance activity to ODM as directed. ODM requires appeal and grievance activity to be submitted at least monthly in an electronic data file format pursuant to the *Appeal File and Submission Specifications* and *Grievance File and Submission Specifications*.

The appeal data file and the grievance data file must include all appeal and grievance activity, respectively, for the previous month, and must be submitted by the ODM-specified due date. These data files must be submitted in the ODM-specified format and with the ODM-specified filename in order to be successfully processed.

MCOPs who fail to submit their monthly electronic data files to the ODM by the specified due date or who fail to resubmit, by no later than the end of that month, a file which meets the data quality requirements will be subject to sanctions as provided in Appendix N of this Provider agreement.

### **5. UTILIZATION MANAGEMENT DATA**

Pursuant to OAC rules 5160-58-01.1 and 5160-26-03.1, the MCOP is required to submit information on prior authorization requests as directed by ODM. ODM requires information on prior authorization requests to be submitted at least bi-weekly in electronic data file formats pursuant to the *Utilization Management Tracking Database: Prior Authorization File and Submission Specifications* document.

## **6. HEALTH OUTCOMES SURVEY (HOS) DATA**

The MCOP is required to collect, report, and submit to ODM HOS data for the full set of HOS measures reported to CMS by the MCOP for applicable MyCare Ohio members per CMS' *Reporting Requirements for 2016 HEDIS, HOS and CAHPS Measures*.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with this data submission requirement.

## **7. NURSING FACILITY 100-DAY THRESHOLD AND DISCHARGE DATA**

### **7.a. Timely Submission of Nursing Facility 100-day Threshold and Discharge Data**

MCOPs are required to collect, report, and submit nursing facility 100-day threshold and discharge data as specified in the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement*. Individual member records must be submitted within 30 business days of the NF LOC (100-day threshold) date and date of discharge, and in every case, NF LOC (100-day threshold) dates must be submitted in accordance with dates specified by ODM to comply with the MEMA timeframes specified in Appendix E.

The individual member records 100-day threshold and discharge dates must be complete and accurate as compared with associated medical records and in accordance with the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement*.

The MCOP must also submit a letter of certification, using the form required by ODM, with each nursing facility admission and discharge data submission file. ODM will use a sample of the NF LOC data to determine compliance.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with this data submission requirement.

## **8. MYCARE OHIO QUARTERLY ENROLLMENT FILES**

Accurate and complete MCOP enrollment records are a critical component of determining accurate rates for measures where member enrollment is used as the basis for calculating rates. In order to ensure the most accurate and complete enrollment records possible for each MCOP, ODM is creating quarterly enrollment files to be sent to the MCOPs for the purpose of enrollment verification. Details regarding specifications for these enrollment files can be found in *ODM's MyCare Ohio Plan Quarterly Enrollment Data File Specifications*.

Effective July 2016, MCOPs may voluntarily submit to ODM on a quarterly basis addition and deletion files for member enrollment spans. These file submissions must be accompanied by a data certification letter, using the form required by ODM. Specifications for submitting the addition and deletion files, and instructions for submitting the associated data certification letter,

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are provided in ODM's *MyCare Ohio Plan Addition and Deletion Enrollment Data File Specifications*.

As this file submission is voluntary, no penalty will be assessed for failure to submit the required data certification letter, however, ODM will not utilize any MCOP files submitted under this section that are not accompanied by the associated data certification letter.

## APPENDIX M

### QUALITY MEASURES AND STANDARDS

The Ohio Department of Medicaid (ODM) has established Quality Measures and Standards to evaluate MyCare Ohio Plan (MCOP) performance in key program areas (i.e., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and focus areas of the ODM Quality Strategy. Each measure has a Minimum Performance Standard. Failure to meet a Minimum Performance Standard will result in the assessment of a noncompliance penalty. See Appendix N of this Provider Agreement for sanctions for noncompliance with the performance standards. Certain measures are also used to determine the Medicaid quality withhold amount that an MCOP may earn back for a contract year per Appendix O, *Quality Withholds*, and/or per Section 4 of the Three-Way Contract between the MCOP, CMS and ODM (the Three-Way).

The measures utilized for performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ, HOS, CAHPS, MDS, CMS, etc.), widely used for evaluation of Medicaid/Medicare managed care industry data, or are Ohio-specific measures designed to monitor goals associated with rebalancing initiatives which provide greater access to home and community based services, as an alternative to facility-based long-term care. Each measure applies to dual benefit members (opt-in population) and/or to Medicaid-only members (opt-out population). Performance measures and standards are subject to change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as deemed relevant.

The performance measures listed in this Appendix are not intended to limit the assessment of other indicators of performance for quality improvement activities. MCOP performance based on multiple measures will be assessed and reported to the MCOPs and others, including Medicare and Medicaid consumers.

#### 1. QUALITY MEASURES AND STANDARDS

MCOPs are evaluated on measures separately for dual benefit members (opt-in population) and Medicaid-only members (opt-out population) using statewide population-specific results that include all regions in which the MCOP has membership. Results for each measure are calculated per MCOP and will either include all of the MCOP's Ohio dual benefit members (opt-in population) and/or Medicaid-only (opt-out population) per the criteria specified by the methodology for the given measure. Separate minimum performance standards may be established for the dual benefit population and the Medicaid-only population.

MCOP performance is assessed using ODM calculated performance measurement data, CMS calculated performance measurement data, and results submitted to ODM and CMS by the MCOPs. The measures in this appendix are calculated in accordance with *CMS' Reporting Requirements for HEDIS, HOS, and CAHPS Measures*, and *The Ohio Department of Medicaid's MyCare Rebalancing and Long Term Care Measures Methods*.

##### 1.a. Measures, Measurement Sets, Standards, and Measurement Years

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The measures and accompanying Minimum Performance Standards and measurement years for the SFY 2016, SFY 2017, SFY 2018, and SFY 2019 contract periods are listed in Table 1. below. Each measure’s corresponding measurement set and applicable consumer population is also provided. For sanctions associated with noncompliance with the performance standards for these measures, see Appendix N of this Provider Agreement.

Table 1. SFY 2016, SFY 2017, SFY 2018, and SFY 2019 Performance Measures, Measurement Sets, Standards, and Measurement Years

Quality Strategy: Population Stream	Measure	Measurement Set	Applicable Population	SFY 2016 Minimum Perf. Std.	SFY 2016 Measurement Year	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
Behavioral Health	Follow-Up After Hospitalization for Mental Illness - 30 Day Follow Up**	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	N/A	≥ 41.2%	CY 2016	TBD	CY 2017	TBD	CY 2018
Behavioral Health	Follow-Up After Hospitalization for Mental Illness 7 Day Follow Up	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 23.0%	CY 2015	N/A	N/A	N/A	N/A	N/A	N/A
Behavioral Health	Anti-depressant Medication Management	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	N/A	Effective Acute Phase Treatment: ≥ 62.8% Effective Continuation Phase Treatment: ≥ 47.4%	CY 2016	TBD	CY2017	TBD	CY 2018
Chronic Conditions	Controlling High Blood Pressure **	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 58.9%	CY 2015	≥ 47.0%	CY 2016	TBD	CY 2017	TBD	CY 2018
Chronic Conditions	Comprehensive Diabetes Care - HbA1c Control (<8.0%)	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	CY 2015	≥ 58.3%	CY 2016	TBD	CY 2017	TBD	CY 2018

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Chronic Conditions	Part D Medication Adherence for Diabetes Medications **	CMS	Dual Benefits Members (Opt-In)	≥ 73.0%	CY 2015	≥ 69.0%	CY 2016	TBD	CY 2017	TBD	CY 2017
Healthy Adults	Flu Vaccinations for Adults Ages 65 and	CAHPS	Dual Benefits Members (Opt-In)	≥ 69.0%	CY 2015 (Survey conducted in CY 2016)	≥ 63.0%	CY 2016 (Survey conducted in CY 2017)	TBD	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018
Healthy Adults	Falls Risk Management – Managing Fall Risk **	NCQA/HEDIS/HOS	Dual Benefits Members (Opt-In)	≥ 55.0%	CY 2015	≥ 53.0%	CY 2016	TBD	CY 2017	TBD	CY 2018
Healthy Adults	Breast Cancer Screening	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N A	CY 2015	≥ 66.0%	CY 2016	TBD	CY 2017	TBD	CY 2018

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Quality Strategy: Population Stream	Measure	Measurement Set	Applicable Population	SFY 2016 Minimum Perf. Std.	SFY 2016 Measurement Year	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
Integrating Care	Plan All Cause Readmissions – Observed Readmissions (Num/Den)	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	CY 2015	≤ 11.0%	CY 2016	TBD	CY 2017	TBD	CY 2018
	Adults' Access to Preventive/Ambulatory Health Services	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 94.6%	CY 2015	≥ 94.0%	CY 2016	TBD	CY 2017	TBD	CY 2018
	Getting Appointments and Care Quickly*	CAHPS	Dual Benefits Members (Opt-In)	N/A	CY 2015 (Survey conducted in CY 2016)	≥ 74.0%	CY 2016 (Survey conducted in CY 2017)	TBD	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018
	Satisfaction with Customer Service*	CAHPS	Dual Benefits Members (Opt-In)	N/A	CY 2015 (Survey conducted in CY 2016)	≥ 85.0%	CY 2016 (Survey conducted in CY 2017)	TBD	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018

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							2017 )					
	Care for Older Adults - Medication Review, 66 & Older	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 71.0%	CY 2015	≥ 60.0%	CY 2016	TBD	CY 2017	TBD	CY 2018	
	Care for Older Adults - Functional Status Assessment, 66 & Older	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 59.0%	CY 2015	≥ 54.0%	CY 2016	TBD	CY 2017	TBD	CY 2018	
	Care for Older Adults - Pain Assessment, 66 & Older	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 60.0%	CY 2015	≥ 62.0%	CY 2016	TBD	CY 2017	TBD	CY 2018	
Improving and Rebalancing Long-Term Care	Nursing Facility Diversion Measure* **	Ohio-Specific	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≥5% decrease from CY 2013 (baseline year)	CY 2015	TBD	CY 2016	TBD	CY 2017	TBD	CY 2018	
	Long Term Care Rebalancing Measure	Ohio-Specific	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≥5% increase from CY 2013 (baseline year)	CY 2015	TBD	CY 2016	TBD	CY 2017	TBD	CY 2018	
	Long Term Care Overall Balance Measure**	Ohio-Specific	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≥5% decrease from CY 2013 (baseline year)	CY 2015	TBD)	CY 2016	TBD	CY 2017	TBD	CY 2018	
	Percent of residents whose need for help with daily activities has increased	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 15.2%	CY 2015	≤ 15.2%	CY 2016	TBD	CY 2017	TBD	CY 2018	
	Percent of residents who were	RTI International/MDS	Dual Benefits Members (Opt-In)	≤ 2.1%		≤ 2.1%		TBD		TBD	CY 2018	

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	physically restrained		and Medicaid-Only Members (Opt-Out)		CY 2015		CY 2016		CY 2017		
	Percent of residents experiencing on or more falls with a major injury	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 3.6%	CY 2015	≤ 3.6%	CY 2016	TBD	CY 2017	TBD	CY 2018
	Percent of residents with urinary tract infection	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 5.8%	CY 2015	≤ 5.8%	CY 2016	TBD	CY 2017	TBD	CY 2018
	Percent of high-risk residents with pressure ulcers	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 5.6%	CY 2015	≤ 5.6%	CY 2016	TBD	CY 2017	TBD	CY 2018
	Percent of residents who have/had a catheter inserted and left in their bladder	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 3.0%	CY 2015	≤ 3.0%	CY 2016	TBD	CY 2017	TBD	CY 2018

\* Quality withhold measure for Demonstration Year 1 (CY 2014 and CY 2015).

\*\* Quality withhold measure for Demonstration Years 2 (CY 2016) and 3 (CY 2017). Note: the Plan All Cause Readmissions rate included in the draft Medicare-Medicaid Quality Withhold Technical Notes (DY 2&3) is the Observed Readmissions rate.

**2. NOTES**

**2.a. Measures and Measurement Periods**

ODM reserves the right to revise the measures and measurement periods referenced in this Appendix (and their corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise

noted, the most recent report or study finalized prior to the end of the contract period will be used in determining an MCOP's performance level for that contract period.

## **2.b. Performance Standards – Compliance Determination**

In the event that an MCOP's performance cannot be evaluated for a performance measure and/or a measurement period referenced in this appendix, ODM will deem the MCOP to have met or to have not met the standard(s) for that particular measure and measurement period depending on the circumstances involved (e.g., if a HEDIS measure was assigned an audit result of "Not Report" on the MCOP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCOP, ODM would deem the MCOP to have not met the standard(s) for that measure and measurement period).

## **2.c. Performance Standards – Retrospective Adjustment**

ODM will implement the use of a uniform methodology, as needed, for the retrospective adjustment of any Minimum Performance Standard referenced in this Appendix, except for the CAHPS measure standards. This methodology will be implemented at ODM's discretion when all three of the following criteria are met.

- The methodology for the standard's associated measure is revised. Note, for HEDIS measures, ODM will not adjust performance measure standards retrospectively due to procedural changes such as revisions to medical record hybrid review timelines.
- For the year in which the methodology is revised, the performance results for all Ohio MCOPs all increase or all decrease when compared to the standard-setting year. Note, this excludes MCOPs without results for both years.
- For the year in which the methodology is revised, the performance results for three or more MCOPs each change by at least three percentage points (e.g., increase from 56.0% to 59.0%) when compared to the standard-setting year.

For a comprehensive description of the standard adjustment methodology, see *ODM's MyCare Ohio Methods for the Retrospective Adjustment of Quality and Withhold Measure Standards*.

## APPENDIX N

### MYCARE OHIO COMPLIANCE ASSESSMENT SYSTEM

#### I. General Provisions of the Compliance Assessment System

- A. The Compliance Assessment System (CAS) sets forth sanctions that may be assessed by the Ohio Department of Medicaid (ODM) against the MyCare Ohio Plan (MCOP) if the MCOP is found to have violated the Three-Way Contract between ODM, CMS and the MCOP, this Provider Agreement, or applicable law. It does not in any way limit ODM from requiring Corrective Action Plans (CAPs) and program improvements, or from imposing any of the sanctions specified in OAC rule 5160-26-10 (applicable to MyCare Ohio pursuant to rule 5160-58-01.1) or any other additional compliance actions, including the proposed termination, amendment, or nonrenewal of this Provider Agreement.
- B. As stipulated in OAC rule 5160-26-10, regardless of whether ODM imposes a sanction, the MCOP is required to initiate corrective action for any MCOP program violation or deficiency as soon as the violation or deficiency is identified by the MCOP or ODM. The MCOP is required to report to ODM when it becomes aware of any violation that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the MCOP to deliver covered services, or affect the member's ability to access covered services.
- C. If ODM determines that an MCOP has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act that are not specifically identified within this Provider Agreement, ODM may (1) require the MCOP to permit any of its members to disenroll from the MCOP without cause, or (2) suspend any further new member enrollments to the MCOP, or both.
- D. Program violations that reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODM first becomes aware of this noncompliance.
- E. ODM retains the right to use its discretion to determine and apply the most appropriate sanction based on the severity of the noncompliance, a pattern of repeated noncompliance, and number of beneficiaries affected. In instances where the MCOP is able to document, to the satisfaction of ODM, that the violation and precipitating circumstances were beyond its control and could not reasonably have been foreseen (e.g. a construction crew severs a phone line, a lightning strike disables a computer system, etc.), ODM may in its discretion utilize alternative methods (i.e. performance improvement plan, remediating plans, etc.) in lieu of the imposition of sanctions/remedial actions as defined in section II of this appendix.
- F. ODM will issue all notices of noncompliance in writing to the identified MCOP contact.
- G. Actions recommended or issued by the Contract Management Team (CMT) as defined in the

Three-Way Contract in no way limit ODM's authority to impose sanctions and remedial actions under this Provider Agreement. ODM will take into consideration any sanctions or actions taken by the CMT when deciding whether and what type of sanctions/remedial actions to take for violations of this Provider Agreement.

## **II. Types of Sanctions/Remedial Actions**

ODM may impose sanctions/remedial actions, including, but not limited to, the items listed below.

### **A. ODM Initiated Corrective Action Plans (CAPs)**

A CAP is a structured activity, process or quality improvement initiative implemented by the MCOP to improve identified operational and clinical quality deficiencies. All CAPs must be submitted in the manner specified by ODM.

MCOPs may be required to develop CAPs for any instance of noncompliance with applicable rules, regulations or contractual requirements; CAPs are not limited to actions taken in this appendix. All CAPs requiring ongoing activity on the part of an MCOP to ensure its compliance with a program requirement will remain in effect until the plan has provided sufficient evidence that it has fulfilled the requirements of the CAP to the satisfaction of ODM. All CAPs requiring implementation of quality improvement initiatives will remain in effect for at least twelve months from the date of implementation.

Where ODM has determined the specific action which must be implemented by the MCOP or if the MCOP has failed to submit a CAP, ODM may require the MCOP to comply with an ODM-developed or "directed" CAP.

Where a sanction is assessed for a violation in which an MCOP has previously been assessed a CAP (or any sanction or any other related written correspondence), the MCOP may be assessed escalating sanctions.

### **B. Financial Sanctions**

#### **B.1. Financial Sanctions Assessed Due to Accumulated Points**

On the effective date of the Three-Way between CMS, ODM and the MCOP, the MCOP shall begin with 0 points. Points will accumulate over a rolling 12-month schedule. Points more than 12 months old will expire.

No points will be assigned for a violation if an MCOP is able to document that the precipitating circumstances were completely beyond its control and could not reasonably have been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.).

In cases where an MCOP-contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing), ODM may assess points unless to the satisfaction of ODM: (1) the MCOP can document that it provided sufficient notification or education to providers of applicable program requirements and prohibited activities; and (2) the MCOP took immediate and appropriate action to correct the problem and to ensure that it will not reoccur. ODM will review repeated incidents and determine whether the MCOP has a systemic problem. If ODM determines that a systemic problem exists, further sanctions or remedial actions may be assessed against the MCOP.

B.1.2.1. 5 Points

ODM may at its discretion assess five points for any instance of noncompliance with applicable rules, regulations or contractual requirements. Instances of noncompliance can include, but are not limited to those that (1) impair a member's or potential enrollee's ability to obtain accurate information regarding MCOP services, (2) violate a care management process, (3) impair a member's or potential enrollee's ability to obtain correct information regarding services or (4) infringe on the rights of a member or potential enrollee. Examples of five point violations include, but are not limited to the following:

- Failure to provide accurate provider panel information.
- Failure to provide member materials to new members in a timely manner.
- Failure to comply with appeal, grievance, or state hearing requirements, including the failure to notify a member of his or her right to a state hearing when the MCOP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to staff a 24-hour call-in system with appropriate trained medical personnel.
- Failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Provision of false, inaccurate or materially misleading information to ODM, health care providers, the MCOP's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify ODM, or members, of provider panel terminations.
- Failure to update website provider directories as required.
- Failure to comply with an open CAP or a CAP closed in the last 12 months.
- Failure to meet provider network performance standards.
- A violation of a care management process specified in Section 2.5.3 of the Three-Way, or Appendix K of the Provider Agreement that does not meet the standards for a 10 point violation. Examples include but are not limited to the following:
  - Failure to ensure that staff performing care management functions are operating within their professional scope of practice, are appropriately responding to a member's care management needs, or are complying with the state's licensure/credentialing requirements;
  - Failure to adequately assess an individual's needs including the evaluation

of mandatory assessment domains;

- Failure to update an assessment upon a change in health status, needs or significant health care event;
- Failure to develop or update a care plan that appropriately addresses assessed needs of a member;
- Failure to monitor the care plan;
- Failure to complete a care gap analysis that identifies gaps between recommended care and care that is received by a member;
- Failure to update the care plan in a timely manner when gaps in care or change in need are identified;
- Failure to coordinate care for a member across providers, specialists, and team members, as appropriate;
- Failure to adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls;
- Failure to make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; conduct timely follow up with the member and provider, as appropriate; or arrange for services specified in the discharge/transition plan; or
- Failure to adhere to home and community-based services (HCBS) waiver service coordination and operational requirements in the Three-Way, Section 2.5.3.3.5.4, and the Ohio approved HCBS 1915(c) waiver for MyCare Ohio.

B.1.2.2. 10 Points

ODM may assess ten points when an MCOP fails to meet a program requirement that could, as determined by ODM: (1) affect the ability of the MCOP to deliver, or a member to access, covered services; (2) place a member at risk for a negative health outcome; or (3) jeopardize the safety and welfare of a member. Examples include, but are not limited to, the following:

- Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).
- Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member.
- Failure to provide medically-necessary Medicare or Medicaid covered services to members.
- Failure to process prior authorization requests within the prescribed time frames.
- Repeated failure to comply with an open CAP or a CAP closed in the last twelve months.
- The imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the MyCare Ohio demonstration project.
- Misrepresentation or falsification of information that the MCOP furnishes to ODM.

- Misrepresentation or falsification of information that the MCOP furnishes to a member, potential member, or health care provider.
- Failure to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
- Violation of a care management process, including HCBS 1915(c) waiver operations, as specified in the Three-Way, Section 2.5.3 or the Provider Agreement Appendix K.

### B.1.2.3. Progressive Sanctions Based on Accumulated Points

Progressive sanctions will be based on the number of points accumulated at the time of the most recent incident. A CAP or other sanction may be imposed in addition to the fines listed below. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	CAP + No fine
16-25 Points	CAP + \$5,000 fine
26-50 Points	CAP + \$10,000 fine
51-70 Points	CAP + \$20,000 fine
71-100 Points	CAP + \$30,000 fine
100+ Points	Proposed Provider Agreement Termination

## B.2 Specific Pre-Determined Sanctions

### B.2.1. Adequate network-minimum provider panel requirements

Any deficiencies in an MCOP's provider network specified the Provider Agreement or the Three-Way may result in the assessment of a \$1,000 nonrefundable fine for each category (dental, vision, waiver providers etc.) and for each county/zip code. Compliance will be assessed at least quarterly.

ODM may assess additional sanctions (e.g. CAPs, points, fines) if (1) an MCOP violates any other provider panel requirements contained within either the Three-Way or Medicaid provider agreement or (2) an MCOP's member has experienced problems in accessing necessary services because of noncompliance by a provider within the MCOP's panel.

### B.2.2. Late Submissions

B.2.2.1 Submission of data and documentation to ODM

All submissions, data and documentation submitted by an MCOP must be received by ODM within the specified deadline and must represent the MCOP in an honest and forthright manner. If the MCOP fails to provide ODM with any required submission, data or documentation, (with the exception of incident management documentation referenced in B.2.2.2) ODM may assess a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM. Assessments for late submissions will be done monthly.

B.2.2.2. Submission of incident management documentation to ODM or PCG

If an MCOP fails to provide the requested information to ODM or PCG, in accordance with the defined “ODM MyCare Ohio Incident Escalation Procedure,” ODM may assess a nonrefundable fine of \$1,000 per incident record, per day until the requested information is provided.

B.2.2.3 Extension requests

With the exception of incident management documentation, if an MCOP is unable to meet a program deadline or data/documentation submission deadline, the MCOP must submit a written request to its Contract Administrator for an extension of the deadline, as soon as possible, but no later than 3 PM, EST, on the date of the deadline in question. Requests for extensions should only be submitted where unforeseeable circumstances have made it impossible for the MCOP to meet a deadline stipulated by ODM and will not be approved for incident management documentation. All such requests will be evaluated upon this standard. ODM may assess a compliance action against an entity, unless written approval for an extension of the deadline has been granted.

B.2.3. Noncompliance with Claims Adjudication Requirements

If ODM finds that an MCOP is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, ODM may assess the MCOP with a monetary sanction of \$20,000 per day for the period of noncompliance. Additionally, the MCOP may be assessed 5 points per incident of noncompliance.

B.2.4 Noncompliance with Financial Performance Measures and/or the Submission of Financial Statements

If the MCOP fails to meet any financial performance measure set forth in Sections 2.13 or 4.2.6 of the Three-Way or fails to submit to the Ohio Department of Insurance (ODI) financial statements by the due date set by ODI, then ODM may impose upon the MCOP a CAP, or a freeze on the enrollment of new members, or both. The MCOP shall submit financial statements to ODM by ODI’s originally specified due date unless ODM grants an extension to the MCOP in writing.

B.2.5 Noncompliance with Reinsurance Requirements

If ODM determines that (1) an MCOP has failed to maintain reinsurance coverage as set

forth in 2.13.4. of the Three-Way, (2) an MCOP's deductible exceeds \$100,000 without approval from ODM, or (3) an MCOP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODM, then ODM may require the MCOP to pay a monetary sanction to ODM. The amount of the sanction will be the lesser of (1) 10% of the difference between the estimated amount of what the MCOP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCOP actually paid while it was out of compliance or (2) \$50,000.

If ODM determines that an MCOP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, ODM may subject the MCOP to a CAP.

#### B.2.6 Noncompliance with Prompt Payment

ODM may impose progressive sanctions on an MCOP that does not comply with the prompt pay requirements as specified in 42 CFR 447.46 and Section 5.1.9 of the Three-Way.

- The first instance of noncompliance during a rolling 12-month period: ODM may assess a refundable fine equal to the greater of, one quarter of one percent of the amount calculated in accordance with section B.3.2. of this appendix, or 25% of the total dollar amount of clean claims not paid within the timeframes outlined in 42 CFR 447.46 and Section 5.1.9 of the Three-Way. The refundable fine amount will be returned to the MCOP if ODM determines the MCOP is in full compliance with the prompt pay standards within the five consecutive reporting periods following the report period for which the refundable fine was issued.
- The second instance of noncompliance during a rolling 12-month period: ODM may assess a nonrefundable fine equal to the greater of, one half of one percent of the amount calculated in accordance with section B.3.2. of this appendix, or 50% of the total dollar amount of clean claims not paid within the timeframes outlined in 42 CFR 447.46 and Section 5.1.9 of the Three-Way.
- Subsequent violations during a rolling 12-month period may result in an enrollment freeze of not less than three months duration or until the MCP has come back into compliance.

#### B.2.7. Noncompliance with Clinical Laboratory Improvement Amendments (CLIA)

If an MCOP fails to comply with CLIA requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of a \$1,000 for each documented violation.

B.2.8. Noncompliance with Abortion and Sterilization Hysterectomy Requirements

If an MCOP fails to comply with abortion and sterilization requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of \$2,000 for each documented violation. Additionally, MCOPs must take all appropriate action to correct each violation documented by ODM.

B.2.9. Refusal to Comply with Program Requirements

If ODM has instructed an MCOP that it must comply with a specific program requirement and the MCOP refuses, such refusal constitutes documentation that the MCOP is no longer operating in the best interests of the MCOP's members or the state of Ohio, and ODM may move to terminate or non-renew the MCOP's provider agreement.

B.2.10. Data Reporting Requirements and Data Quality Measures

ODM reserves the right to withhold an assessment of noncompliance under section B.2.10. due to unforeseeable circumstances.

B.2.10.1 Data Reporting Requirements

B.2.10.1.1. Annual Submission of MCOP Self-Reported, Audited HEDIS Data Performance is monitored annually. If an MCOP fails to submit its self-reported, audited HEDIS data as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the self-reported, audited HEDIS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of the Provider Agreement for the corresponding contract period.

B.2.10.1.2 Annual Submission of Final HEDIS Audit Report (FAR)

Performance is monitored annually. If an MCOP fails to submit its FAR as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the self-reported, audited HEDIS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of the Provider Agreement for the corresponding contract period.

ODM will review each MCOP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. An MCOP may be required to submit to ODM requested documentation to account for an NR audit designation. Based on its review of an MCOP's FAR and any NR audit designations assigned, ODM may impose corrective action (such as requiring the MCOP to implement a corrective action plan to resolve data collection and/or reporting issues).

B.2.10.1.3. Data Certification Requirements for HEDIS IDSS Data and HEDIS Audit Report

Performance is monitored annually. If an MCOP fails to submit a required data certification letter to ODM within the required time frame, CMS or ODM may impose a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.10.1.4. Annual Submission of MCOP Health Outcomes Survey (HOS) Results

Performance is monitored annually beginning with the 2016 HOS survey. If an MCOP fails to submit its HOS data as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the HOS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of the Provider Agreement for the corresponding contract period.

B.2.10.1.5. Complete and Accurate Submission of Nursing Facility 100-Day Threshold and Discharge Data

Performance may be monitored quarterly and annually. The nursing facility admission and discharge data set may be subject to an audit for completeness and accuracy by ODM, or a vendor contracted by ODM. Any overpayments made by ODM to the MCOP as a result of inaccurate or incomplete nursing facility 100-day threshold or discharge data submitted by the MCOP will result in ODM recouping the overpayment(s).

If an MCOP fails to submit complete and accurate nursing facility 100-day threshold and discharge data as specified by ODM, the MCOP will be considered non-compliant with the standards established in Appendix M of the MyCare Ohio Provider Agreement for the corresponding contract period. ODM may issue the following sanctions:

- The first instance, or subsequent but nonconsecutive instance, of noncompliance: ODM may impose a nonrefundable monetary sanction in the amount of one quarter of one percent of the current month's premium payment.
- The second consecutive instance of noncompliance: ODM may impose a nonrefundable monetary sanction in the amount of one half of one percent of the current month's premium payment.
- The third consecutive, and any additional consecutive, instance of noncompliance: ODM may terminate the MCOP's Provider Agreement.

B.2.10.2. Data Quality Measures

The MCOP must submit to ODM, by the specified deadline and according to specifications set by ODM, all required data files and requested documentation needed to calculate each measure listed below. If an MCOP fails to comply with this requirement for any measure listed below, the MCOP will be considered noncompliant with the standard(s) for that measure. Data quality report periods, measures, standards and requirements are specified in Appendix L of the Provider Agreement and *ODM Measures for the MyCare Ohio Encounter Data Quality Measures*.

Sanctions for noncompliance are assessed for each MCOP as described for each measure.

#### B.2.10.2.1 Encounter Data Volume

Performance is monitored once every quarter for the entire measurement period for each of the following populations and service combinations: 1) Medicaid and Medicare services for dual benefit members; and 2) Medicaid services for Medicaid-only members.

Sanctions for non-compliance will be assessed separately, by population and service combination. For each population (i.e., dual benefit members vs. Medicaid-only members) and service combination (i.e., Medicaid vs. Medicare), if the standard is not met for every service category in all quarters of the measurement period, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

#### B.2.10.2.2. Rejected Encounters

Performance is monitored once every quarter for Measure 1 and once every month for Measure 2 in Appendix L of the Provider Agreement. Compliance determination with the standard applies only to the measurement period under consideration and does not include performance in previous measurement periods. Files in the ODM-specified medium per format that are totally rejected will not be considered in the determination of noncompliance. If the standard is not met for every file type, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member

enrollment freeze. Special consideration may be made for MCOPs with less than 1,000 members.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

#### B.2.10.2.3. Acceptance Rate

Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months. If the standard is not met for every file type, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Special consideration may be made for MCOPs with less than 1,000 members.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

#### B.2.10.2.4. Encounter Data Accuracy Measure

The first time an MCOP is determined to be noncompliant with the standard for either level 1 or level 2 for this measure, the MCOP must implement a CAP which identifies interventions and a timeline for resolving data quality issues related to payments. Additional reports to ODM addressing targeted areas of deficiencies and progress implementing data quality improvement activities may be required. Upon all subsequent measurements of performance, if an MCOP is again determined to be noncompliant with the standard for either level 1 or level 2 for this measure, ODM may impose a monetary sanction of one percent of the amount calculated in accordance with section B.3.2. of this appendix.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued.

#### B.2.10.2.5. Incomplete Rendering Provider Data

Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCOP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

#### B.2.10.2.6. NPI Provider Number Usage without Medicaid/Reporting Provider Numbers

Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCOP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued. A new member enrollment freeze issued under this section will be lifted after ODM determines the MCOP is in full compliance with this program requirement.

B.2.10.2.7 Encounter Submissions per ODM Encounter Data Submission Schedule

Performance is monitored once every month. If the standard is not met for the measurement period, the MCOP will be noncompliant for the measurement period.

Effective January 2015, ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may impose a monetary sanction of one percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued.

B.2.10.2.8. Timeliness of Encounter Data Submission

Performance is monitored once every month. If the standard is not met for the measurement period, the MCOP will be noncompliant for the measurement period.

Effective SFY 2016 (July 2015), ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may impose a monetary sanction of one percent of the amount calculated in accordance with section B.3.2. of this appendix. If an MCOP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a monetary sanction of two percent of the amount calculated in accordance with section B.3.2. of this appendix.

A monetary sanction issued under this section will be returned to the MCOP if ODM determines the MCOP is in full compliance with this program requirement within the five consecutive report periods following the report period for which the monetary sanction was issued.

B.2.11. Quality Measures

The MCOP must submit to ODM, by the specified deadline and according to ODM specifications, all required data files and requested documentation needed to assess the quality measures specified any quality measure listed in Appendix M of the Provider Agreement, the MCOP will be considered noncompliant with the standard(s) for that measure.

ODM reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

For each measure and population (i.e., dual benefit members and Medicaid-only members) as specified in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of the Provider Agreement, one rate is calculated. Each rate per specified population has an associated Minimum Performance Standard. When an MCOP fails to meet a Minimum Performance Standard listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of the Provider Agreement, for a measure and specified population for which noncompliance sanctions are applicable, the MCOP will be assessed a sanction for noncompliance with the standard. ODM has established uniform noncompliance sanctions for these standards.

A series of progressive sanctions may be issued for consecutive instances of noncompliance with the standard established for a given rate and population. For example, two rates, corresponding to the dual benefit member population and Medicaid-only member population, are calculated for the *Long-Term Care Overall Balance* measure. An MCOP failing to meet the standard established for the dual benefit member population rate in three consecutive measurement periods would be subject to progressive sanctions. However, an MCOP failing to meet the standard established for the dual benefit member population rate in one measurement period and the Medicaid-only member population in the next would not be subject to progressive sanctions, as these only apply to the standard established for the same rate and population.

**For the standard established for each rate and specified population** listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of the Provider Agreement, for measures for which noncompliance sanctions are applicable, an MCOP may be assessed sanctions for instances of noncompliance as follows:

- The first instance, or subsequent but nonconsecutive instance, of noncompliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP. If the MCOP is determined to be in full compliance with this program requirement within the following five consecutive report periods, the monetary sanction will be returned.
- The second consecutive instance of noncompliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP. This monetary sanction nonrefundable.
- The third consecutive, and any additional consecutive, instance of noncompliance: ODM may impose a monetary sanction in the amount of one half of one percent of the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP. The monetary sanction is nonrefundable.
- In addition, if ODM determines that an MCOP is noncompliant with greater than 50%

of the applicable quality standards listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement, for which noncompliance sanctions are applicable, for two consecutive contract years, ODM may terminate the MCOP's Provider Agreement.

#### B.2.12. Quality Care

ODM reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

##### B.2.12.1. Administrative Compliance Assessment

Compliance with administrative standards is performed by the external quality review organization, as specified by ODM. For each documented instance of noncompliance with an administrative standard, the MCOP may be required to submit a CAP as specified by ODM to remedy the identified deficiency.

##### B.2.12.2. Care Management Data Submission

The MCOP must submit to ODM all required care management data as specified in ODM's *MyCare Ohio Care Management Data Submission Specifications*. If an MCOP fails to comply with the timely submission requirement, then ODM may impose a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM.

##### B.2.12.3. Care Management Data Certification Requirements

If an MCOP fails to submit a required Care Management data certification letter to ODM within the required time frame, ODM may impose a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM.

##### B.2.12.4. HCBS Waiver Operational Reporting Requirements

The MCOP must submit to ODM all required HCBS waiver operational reporting requirements as specified by ODM or CMS or both. If an MCOP fails to submit a required reporting to ODM within the required time frame, CMS or ODM may impose a nonrefundable fine of \$100 per day, unless the MCOP requests and is granted an extension by ODM.

##### B.2.12.5. Care Management Staffing Ratio

ODM may assess sanctions on the MCOP for instances of non-compliance with the care management staffing ratio standards specified in Appendix K.1.g.ii. of the Provider Agreement as follows:

- First instance, or subsequent but nonconsecutive instance, of non-compliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP. If the MCOP is determined to be in full compliance with this program requirement within the following five consecutive report periods, the monetary sanction will be returned.
- Second consecutive instance of noncompliance: ODM may impose a monetary

sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.

- Third consecutive, and any additional consecutive, instance of noncompliance: ODM may impose a monetary sanction in the amount of one half of one percent of the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.
- In addition, upon a fourth consecutive instance of noncompliance: ODM may terminate the MCOP's Provider Agreement.

#### B.2.12.6. Comprehensive Assessment measures

For the standard established for each measure listed in Appendix K.1.g.iv., an MCOP may be assessed sanctions for instances of noncompliance as follows:

- First instance, or subsequent but nonconsecutive instance, of noncompliance: ODM may impose a monetary sanction in the amount of one quarter of one percent of the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.
- Second consecutive instance of noncompliance: ODM may impose a monetary sanction in the amount of one half of one percent of the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.
- Third consecutive, and any additional consecutive, instance of noncompliance: ODM may impose a monetary sanction in the amount of three-quarters of one percent of the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP. This amount is nonrefundable.
- Fourth consecutive instance of noncompliance: ODM may terminate the MCOP's provider agreement.

#### B.2.12.7. Maintenance of National Committee for Quality Assurance Health Plan Accreditation

For the standard established in Section 2.2.4 of the Three-Way, ODM may assess the following sanctions for non-compliance:

If the MCOP receives a Provisional accreditation status, the MCOP will be required to complete a resurvey within 12 months of the accreditation decision. If the resurvey results in a Provisional or Denied status, ODM will consider this a material breach of the provider agreement and may terminate the provider agreement with the MCOP.

If the MCOP receives a Denied accreditation status, then ODM will consider this a material breach of the provider agreement and may terminate the provider agreement with the MCOP.

#### B.2.13. Non-compliance with Provision of Transportation Services

If the MCOP fails to comply with the transportation requirements specified in Appendix C.19.a. of this Provider Agreement, or if an MCOP fails to transport a member to a pre-scheduled appointment on time, which results in a missed appointment, when providing Medicaid-covered transportation services and when members must travel more than 30 miles to receive services, ODM may impose a nonrefundable fine in the amount of \$1,000 for each violation. ODM may assess additional sanctions (e.g., CAPs, points, fines) as provided for in section II of this appendix for any violation of the Medicaid-covered transportation services and applicable requirements.

#### B.3. Fines

Refundable or nonrefundable fines may be assessed separately or in combination with other sanctions/remedial actions. The total fines assessed in any one month will not exceed 15% of one month's payments from ODM to the MCOP. Unless otherwise stated, all fines are nonrefundable.

B.3.1. Refundable and nonrefundable monetary sanctions/assurances must be paid by the MCOP to ODM within thirty calendar days of receipt of the invoice by the MCOP, or as otherwise directed by ODM in writing. In addition, per ORC Section 131.02, payments owed to the State not received within forty-five calendar days will be certified to the Attorney General's (AG's) office. The AG's Office will assess the appropriate collection fee for MCOP payments certified to the AG's Office.

B.3.2. For monetary sanctions calculated in accordance with this section, ODM will use the MCOP's average monthly net premium and delivery payment amount for the twelve months prior to the month in which the compliance action is issued to the MCOP.

B.3.3. Unless otherwise specified, any monies collected through the imposition of a refundable fine will be returned to the MCOP (minus any applicable collection fees owed to the AG's Office if the MCOP has been delinquent in submitting payment) after it has demonstrated full compliance with the particular program requirement, as determined by ODM.

B.3.4. An MCOP is required to submit a written request for refund to ODM at the time it believes is appropriate before a refund of monies will be considered.

B.3.5. Refundable monetary sanctions issued under sections B.2.10., B.2.11., and B.2.12. of this appendix will be returned to the MCOP in the event ODM replaces or eliminates the sanction's applicable measure(s) from the Provider Agreement for the measurement period immediately following the measurement period for which the sanction was assessed.

#### B.4. New Enrollment Freezes

Notwithstanding any other sanction or point assessment that ODM may impose on the MCOP under this Provider Agreement, ODM may prohibit an MCOP from receiving new enrollment through consumer initiated selection or the assignment process if any of the following occur: (1) the MCOP has accumulated a total of 51 or more points during a rolling 12-month period; (2) the MCOP has failed to fully implement a plan of correction within the designated time frame; (3) circumstances exist that potentially jeopardize the MCOP's members' access to care, as solely determined by ODM; or (4) the MCOP is found to have a pattern of repeated or ongoing noncompliance, as solely determined by ODM. Examples of circumstances that ODM may consider as jeopardizing member access to care include, but are not limited to, the following:

- The MCOP has been found by ODM to be noncompliant with the prompt payment or the non-contracting provider payment requirements;
- The MCOP has been found by ODM to be noncompliant with the provider panel requirements specified in Appendix H of the Provider Agreement;
- The MCOP has refused to comply with a program requirement after ODM has directed the MCOP to comply with the specific program requirement;
- The MCOP has received notice of proposed or implemented adverse action by the ODI; or
- The MCOP has failed to provide adequate provider or administrative capacity.

Payments provided for under the Provider Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.730.

B.4.1. New Member Enrollment freezes issued under section B.2.10 of this appendix may be lifted in the event ODM replaces or eliminates the sanction's applicable measure(s) from the Provider Agreement for the measurement period immediately following the measurement period for which the sanction was assessed.

B.4.2. Unless otherwise specified, new enrollment freezes issued under this appendix may be lifted after the MCOP is determined to be in full compliance with the applicable program requirement, and the violations or deficiencies are resolved to the satisfaction of ODM.

#### B.5. Reduction of Assignments

ODM has discretion over how member auto-assignments are made. ODM may reduce the number of assignments an MCOP receives to assure program stability within a region, or upon a determination that the MCOP lacks sufficient capacity to meet the needs of the increased enrollment volume. ODM may determine that an MCOP has demonstrated a lack of sufficient capacity under circumstances that include, but are not limited to the following:

- The MCOP has failed to maintain an adequate provider network;

- The MCOP has failed to provide new member materials by the member's effective date;
- The MCOP has failed to meet the minimum call center requirements;
- The MCOP has failed to meet the minimum performance standards for members with special health care needs; or
- The MCOP has failed to provide complete and accurate data files regarding appeals or grievances, or its care management program.

#### B.6. Death or Injury to Member

ODM may immediately terminate or suspend this Agreement if an MCOP's failure to perform, or properly perform, any of the requirements in this Agreement results in the death of or serious injury to, an MCOP's member, as determined by ODM.

### **III. Request for Reconsiderations**

Unless otherwise specified below, an MCOP may seek reconsideration of any sanction or remedial action imposed by ODM including CAPs (when a CAP is required for the first violation in a series of progressive compliance actions), points, fines, and member enrollment freezes.

MCOPs may not seek reconsideration of:

- An action by ODM that results in changes to the auto-assignment of members.
- The imposition of directed CAPs as defined in II of this appendix.

The MCOP must submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:

A. An MCOP must submit a request for reconsideration either by email to the designated Contract Administrator (CA), or by overnight mail to ODM's Bureau of Managed Care (BMC). The request for reconsideration must be received by ODM no later than the tenth business day after the date that the MCOP receives notice of the imposition of the remedial action by ODM. If ODM imposes an enrollment freeze based on access to care concerns, the enrollment freeze will be imposed concurrent with initiating notification to the MCOP.

B. A request for reconsideration must explain in detail why the specified sanction should not be imposed. At a minimum, the reconsideration must include: the proposed action being contested; the basis for requesting reconsideration; and any supporting documentation. In considering an MCOP's request for reconsideration, ODM will review only the written material submitted by the MCOP.

C. ODM will take reasonable steps to make a final decision, or request additional information, within ten business days after receiving the request for reconsideration. If ODM requires additional time, the MCOP will be notified in writing.

D. If ODM approves a reconsideration request, in whole, the associated sanctions or remedial

actions will be rescinded. The MCOP will not be required to submit a CAP.

E. If ODM approves, in part, the MCOP's reconsideration request, the sanction, remedial action and/or the points associated with the incident may be rescinded or reduced, at the discretion of ODM. The MCOP may still be required to submit a CAP if ODM, in its discretion, believes that a CAP is still warranted under the circumstances.

F. If ODM denies the MCOP's reconsideration request, any CAP, sanction, remedial action, and/or points outlined in the original notice of noncompliance will be assessed.

**APPENDIX O QUALITY**

**WITHHOLDS**

**Dual Benefit Members Quality Withhold Policies and Measures**

Section 4 of the Three-Way Contract between MCOP, CMS and ODM (the Three-Way) specifies the Quality Withhold policies and measures for the dual benefit members (opt-in population). For the dual benefit members (opt-in population), the quality withhold methodology is specified in *CMS' Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes (DY 1)* for Demonstration Year 1.

**Medicaid-Only Quality Withhold Policies and Measures**

ODM will withhold a percentage of the MCOP's Medicaid-only (opt-out population) capitation rate. The withheld amounts will be repaid subject to the MCOP's performance consistent with established quality thresholds. ODM will evaluate the MCOP's performance according to the specified metrics required in order to determine whether the MCOP will earn back the quality withhold for a given year. Table 1, below identifies the withhold measure and standards for the Medicaid-only members (opt-out population) for Demonstration Year 1. This measure will be for a one percent (1%) withhold. Because Demonstration Year 1 crosses calendar and contract years, the MCOP will be evaluated to determine whether it has met required withhold requirements at the end of both Calendar Year (CY) 2014 and CY 2015. For Demonstration Years 2 and 3, the MCOP will be evaluated to determine whether it has met withhold requirements at the end of CY 2016 and CY 2017, respectively. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year. The quality withhold will increase to two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Year 3. Table 2, below identifies the withhold measures and standards for the Medicaid-only members (opt-out population) for Demonstration Years 2 and 3.

**Table 1. Quality Withhold Measures and Standards for Demonstration Year 1 for Medicaid-Only Members – Contract Period/Measurement Year**

		<b>Demonstration Year 1</b>	
<b>Measure</b>	<b>Source</b>	<b>SFY 2015/CY 2014 Min Perf Standard</b>	<b>SFY 2016/ CY 2015 Min Perf Standard</b>
Nursing Facility Diversion Measure	State-defined measure	5% decrease from CY 2013 (baseline year)	5% decrease from CY 2013 (baseline year)

**Table 2. Quality Withhold Measures and Standards for Demonstration Years 2 and 3 for Medicaid-Only Members – Contract Period/Measurement Year**

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 MyCare Ohio  
 Quality Withholds  
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		<b>Demonstration Year 2</b>	<b>Demonstration Year 3</b>
<b>Measure</b>	<b>Source</b>	<b>SFY 2017/ CY 2016 Min Perf Standard</b>	<b>SFY 2018/ CY 2017 Min Perf Standard</b>
Nursing Facility Diversion Measure	State-defined measure	TBD	TBD
Long Term Care Overall Balance Measure	State-defined measure	TBD	TBD

For Medicaid-only members (opt-out population), 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.

## APPENDIX P

### TERMINATION/NONRENEWAL

#### **1. PLAN-INITIATED TERMINATIONS/NONRENEWALS**

If a MyCare Ohio Plan (MCOP) provides notice of the termination/nonrenewal of this Provider Agreement to ODM, pursuant to Article VIII of this MCOP Provider Agreement (Agreement) or Section 5.5 of the Three-Way Contract (Three-Way) between United States Department of Health and Human Services Centers for Medicare and Medicaid Services, ODM and the MCOP, the MCOP will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

The MCOP agrees to fulfill all duties and obligations as required under Chapter 5160-58 of the Ohio Administrative Code (OAC) and any agreements related to the provision of services for the Medicaid population during periods of time when the MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCOP for the MCOP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCOP for the MCOP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCOP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement. The monetary assurance must be in an amount of either \$50,000 or 5% of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCOP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP must contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the monetary assurance is not received as specified above, ODM may withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement, the monetary assurance will not be refunded to the MCOP.

c. Withhold Amount

Any withhold amount in the managed care program performance payment fund will be retained by ODM.

d. Final Accounting of Amounts Outstanding

The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after the termination/nonrenewal date. Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. Data Files

In order to assist members with continuity of care, the terminating MCOP must create data files to be shared with each newly enrolling MCOP. The data files must be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, pregnant members, and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The terminating MCOP will be responsible for ensuring the accuracy and data quality of the files.

g. Notification

- i. Provider Notification - The MCOP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.
- ii. Member Notification – Unless otherwise notified by ODM, the MCOP must notify its members regarding its provider agreement termination at least 45 days

in advance of the effective date of termination. The member notification must be approved by ODM prior to distribution.

- iii. Prior Authorization Re-Direction Notification - The MCOP must create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCOP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCOP must utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCOP membership.

## **2. ODM-INITIATED TERMINATIONS FOR CAUSE**

- a. If ODM initiates the proposed termination, nonrenewal or amendment of this agreement pursuant to OAC rules 5160-58-01.1 and 5160-26-10 by issuing a proposed adjudication order pursuant to O.R.C. 5164.38, and the MCOP submits a valid appeal of that proposed action pursuant to O.R.C. Chapter 119, the MCOP's provider agreement will be extended through the issuance of an adjudication order in the MCOP's appeal under ORC Chapter 119.

During this time, the MCOP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation under Appendix N of the provider agreement. If the MCOP exceeds 69 points, each subsequent point accrual will result in a \$15,000 nonrefundable fine.

Pursuant to OAC rules 5160-58-01.1 and 5160-26-10, if ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODM may notify the MCOP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCOP without cause. If ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODM may propose to terminate the membership of all of the MCOP's members. The appeal process for reconsideration of the proposed termination of members is as follows:

- All notifications of such a proposed MCOP membership termination will be made by ODM via certified or overnight mail to the identified MCOP contact.
- An MCOP notified by ODM of such a proposed MCOP membership termination will have three working days from the date of receipt to request reconsideration.
- All reconsideration requests must be submitted by either facsimile transmission or

overnight mail to the Director, Ohio Department of Medicaid, and received by 3PM Eastern Time on the third working day following receipt of the ODM notification of termination. The address and fax number to be used in making these requests will be specified in the ODM notification of termination document.

- The MCOP will be responsible for verifying timely receipt of all reconsideration requests. All requests must explain in detail why the proposed MCOP membership termination is not justified. The MCOP's justification for reconsideration will be limited to a review of the written material submitted by the MCOP.
- A final decision or request for additional information will be made by the Director within three working days of receipt of the request for reconsideration. Should the Director require additional time in rendering the final reconsideration decision, the MCOP will be notified of such in writing.
- The proposed MCOP membership termination will not occur while an appeal is under review and pending the Director's decision. If the Director denies the appeal, the MCOP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODM determines that it would be in the best interest of the members.

b. Fulfill Existing Duties and Obligations

The MCOP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-58 and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCOP for the MCOP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCOP for the MCOP's provider agreement time periods.

c. Refundable Monetary Assurance

The MCOP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement. The monetary assurance must be in an amount of either \$50,000 or 5% of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCOP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP must contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP must send copies of the EFT bank confirmations and copies of the invoices to its Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, the MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement, the monetary assurance will not be refunded to the MCOP.

d. Withhold Amount

Any withhold amount in the managed care program performance payment fund will be retained by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. Final Accounting of Amounts Outstanding

The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after the termination/nonrenewal date. Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

In order to assist members with continuity of care, the terminating MCOP must create data files to be shared with each newly enrolling MCOP. The data files must be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, pregnant members and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The terminating MCOP will be responsible for ensuring the accuracy and data quality of the files.

h. Notification

- i. Provider Notification - The MCOP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.
- ii. Prior Authorization Re-Direction Notification - The MCOP must create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCOP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCOP must utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCOP membership.

**3. TERMINATION OR MODIFICATION OF THIS PROVIDER AGREEMENT DUE TO LACK OF FUNDING**

Should this Agreement terminate or be modified due to a lack of available funding as set forth in the Baseline of this Agreement, the MCOP has no right to appeal the selection process under ORC Chapter 119 pursuant to ORC 5164.38 and will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

The MCOP agrees to fulfill all duties and obligations as required under OAC Chapter 5160-58 and any provider agreements related to the provision of services for the Medicaid populations during periods of time when the MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid populations, resolution of provider and consumer complaints for the Medicaid population served by the MCOP for the MCOP provider agreement time periods, and provision of data to support audits related to the Medicaid populations

served by the MCOP for the MCOP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCOP will be required to submit a refundable monetary assurance should the Provider Agreement terminate. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement. The monetary assurance must be in an amount of either \$50,000 or 5% of the capitation amount paid by ODM in the month the termination notice is issued, whichever is greater.

The MCOP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP must contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP must send copies of the EFT bank confirmations and copies of the invoices to its Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, fines or sanctions, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement, the monetary assurance will not be refunded to the MCOP.

c. Withhold Amount

Any withhold amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.

d. Monetary Sanctions

Previously collected refundable monetary sanctions directly and solely related to the termination or modification of this Agreement shall be returned to the MCOP.

e. Final Accounting of Amounts Outstanding

The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six months after a termination/nonrenewal date of this Agreement.

Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

f. Data Files

In order to assist members with continuity of care, the MCOP must create data files if requested by ODM. The data files must be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, pregnant members and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The MCOP will be responsible for ensuring the accuracy and data quality of the files.

g. Provider Notification

The MCOP must notify contracted providers within 30 days of notice from ODM of the effective date of termination or modification of this Agreement. The provider notification must be approved by ODM prior to distribution.

## APPENDIX Q

### PAYMENT REFORM

#### **I. Introduction.**

On January 9, 2013, Governor John Kasich's Advisory Council on Health Care Payment Reform adopted the Catalyst for Payment Reform (CPR) principles as part of a comprehensive strategy to prioritize and coordinate multi-payer health care payment innovation activities in Ohio. The Ohio Department of Medicaid (ODM) is committed to reforming the health care delivery system by designing and implementing systems of payment that signal powerful expectations for improved health care delivery. As such the following principles have been adopted by Ohio Medicaid:

1. Payment reforms should promote health by rewarding the delivery of quality, cost effective and affordable care that is patient-centered and reduces disparities.
2. Health care payments should encourage and reward patient-centered care that coordinates services across the spectrum of providers and care setting while tailoring health care service to the individuals patient's needs.
3. Payment policies should encourage alignment between public and private sectors to promote improvement, innovations and meeting national health priorities, and to maximize the impact of payment decisions of one sector on the other.
4. Decisions about payment should be made through independent processes that are guided by what serves the patient and helps society as a whole, and payment decisions must balance the perspectives of consumers, purchasers, payers, physicians and other health care providers.
5. Payment policies should foster ways to reduce expenditure on administrative processes (e.g., claims payment and adjudications).
6. Reforms to payment should balance the need for urgency against the need to have realistic goals and timelines that take into account the need to change complex systems and geographic and other variations.

In order to improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, there must be significant changes in existing payment structures and methodologies as well as the environment in which payments are made. This Appendix outlines ODM's expectations for how a MyCare Ohio Plan (MCOP) shall achieve progress in the following areas:

- A. Value-Oriented Payment:** The MCOP shall design and implement payment methodologies with its network providers that are designed either to cut waste or reflect value. For the purposes of this Provider Agreement, payments that cut waste are those that by their design reduce unnecessary payment and unnecessary care (e.g. elective cesarean deliveries). Value is defined as the level of the quality of care for the amount of money paid to the provider. Payments designed to reflect value are those that are tied to provider performance so that they may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.
- B. Market Competition and Consumerism:** The MCOP shall design contracting methodologies and payment options and administer the benefit package to members in a manner that enhances competition among providers and reduces unwarranted price and quality variation. To stimulate provider competition further, the MCOP shall establish programs to engage MCOP members to make informed choices and to select evidence-based, cost-effective care.
- C. Transparency:** The MCOP shall participate in ODM initiatives to design and implement member-accessible comparisons of provider information including quality, cost, and patient experience, among providers in the plan’s network. The MCP shall contribute to the program design, provide data as specified by ODM, and publish results in accordance with standards established by the Department.

These commitments are included to support and advance MCOP initiatives to develop a health care market where (a) payment increasingly is designed to improve and reflect the effectiveness and efficiency with which providers deliver care, and (b) consumers are engaged in managing their health, selecting their providers, and sensitive to the cost and quality of services they seek. The term “provider” is defined in OAC rule 5160-58-01. The MCOP must use its best efforts to ensure that these commitments and initiatives apply to the benefits offered and services provided under this Provider Agreement and administered by the MCOP.

## **II. Obligations of MCOP**

### **VALUE-ORIENTED PAYMENT, MARKET COMPETITION & CONSUMERISM**

The MCOP shall implement payment strategies that tie payment to value or reduce waste, as those terms are defined herein. Examples of strategies include the following:

1. Paying providers differentially according to performance (and reinforce with benefit design).
2. Designing approaches to payment that cut waste while not diminishing quality, including reducing unwarranted payment variation.
3. Payments designed to encourage adherence to clinical guidelines. At a minimum, the MCOP must address policies to discourage elective deliveries before 39 weeks.
4. Payment strategies to reduce unwarranted price variation, such as reference or value pricing (e.g. analysis of price variation among network providers by procedure and service types, pilot value pricing programs, encouragement of member value-based pricing information , center of excellence pricing, and rebalance payment between primary and specialty care).

### **III Reporting**

The MCOP must submit a quarterly progress report as specified by ODM that addresses progress towards meeting the obligations as outlined in II above.