# OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
# OHIO MEDICAL ASSISTANCE PROVIDER AGREEMENT
# FOR MANAGED CARE PLAN

This provider agreement is entered into this first day of July, 2010, at Columbus, Franklin County, Ohio, between the State of Ohio, Department of Job and Family Services, (hereinafter referred to as ODJFS) whose principal offices are located in the City of Columbus, County of Franklin, State of Ohio, and _____, Managed Care Plan (hereinafter referred to as MCP), an Ohio for-profit corporation, whose principal office is located in the city of _____, County of _____, State of Ohio.

MCP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and agrees to operate as prescribed by Chapter 5101:3-26 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time.

MCP 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 eligible population described in OAC rule 5101:3-26-02(B) and Appendix B of this Agreement.

ODJFS, as the single state agency designated to administer the Medicaid program under Section 5111.02 of the ORC and Title XIX of the Social Security Act, desires to obtain MCP services for the benefit of certain Medicaid recipients. In so doing, MCP has provided and will continue to provide proof of MCP's capability to provide quality services, efficiently, effectively and economically during the term of this agreement.

This provider agreement is a contract between ODJFS and the undersigned MCP, provider of medical assistance, pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCP agrees to provide comprehensive medical services through the managed care program as provided in Chapter 5101:3-26 of the OAC, assuming the risk of loss, and complying with applicable state statutes, OAC, and Federal statutes, rules, regulations and other requirements, including but not limited to 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. ODJFS enters into this Agreement in reliance upon MCP’s representations that it has the necessary expertise and experience to perform its obligations hereunder, and MCP warrants that it does possess the necessary expertise and experience.

B. MCP agrees to report to the Chief of the Bureau of Policy and Health Plan Services (BPHPS) (hereinafter referred to as BPHPS) or his or her designee as necessary to assure understanding of the responsibilities and satisfactory compliance with this provider agreement.

C. MCP agrees to furnish its support staff and services as necessary for the satisfactory performance of the services as enumerated in this provider agreement.

D. ODJFS may, from time to time as it deems appropriate, communicate specific instructions and requests to MCP concerning the performance of the services described in this provider agreement. Upon such notice and within the designated time frame after receipt of instructions, MCP shall comply with such instructions and fulfill such requests to the satisfaction of the department. It is expressly understood by the parties that these instructions and requests are for the sole purpose of performing the specific tasks requested to ensure satisfactory completion of the services described in this provider agreement, and are not intended to amend or alter this provider agreement or any part thereof.

E. If the MCP previously had a provider agreement with the ODJFS and the provider agreement terminated more than two years prior to the effective date of any new provider agreement, such MCP will be considered a new plan in its first year of operation with the Ohio Medicaid managed care program.

ARTICLE II - TIME OF PERFORMANCE

A. Upon approval by the Director of ODJFS this provider agreement shall be in effect from the date entered through June 30, 2011, unless this provider agreement is suspended or terminated pursuant to Article VIII prior to the termination date, or otherwise amended pursuant to Article IX.

B. It is expressly agreed by the parties that none of the rights, duties and obligations herein shall be binding on either party if award of this Agreement would be contrary to the terms of ORC Section 3517.13, ORC Section 127.16, or ORC Chapter 102.

ARTICLE III - REIMBURSEMENT

A. ODJFS will reimburse MCP in accordance with rule 5101:3-26-09 of the OAC and the appropriate appendices of this Agreement.

ARTICLE IV - RELATIONSHIP OF PARTIES

A. ODJFS and MCP agree that, during the term of this Agreement, MCP shall be engaged by ODJFS solely on an independent contractor basis, and neither MCP nor its personnel shall, at any time or for any purpose, be considered as agents, servants or employees of ODJFS or the state of Ohio. MCP shall therefore be responsible for all MCP's business

expenses, including, but not limited to, employee's wages and salaries, insurance of every type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any.

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

C. While MCP shall be required to render services described hereunder for ODJFS during the term of this Agreement, nothing herein shall be construed to imply, by reason of MCP's engagement hereunder on an independent contractor basis, that ODJFS shall have or may exercise any right of control over MCP with regard to the manner or method of MCP's performance of services hereunder. The management of the work, including the exclusive right to control or direct the manner or means by which the work is performed, remains with MCP. ODJFS retains the right to ensure that MCP's work is in conformity with the terms and conditions of this Agreement.

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

ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS

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

B. MCP represents, warrants, and certifies that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws and Executive Order 2007-01S. MCP further represents, warrants, and certifies that neither MCP nor any of its employees will do any act that is inconsistent with such laws and Executive Order. The Governor's Executive Orders may be found by accessing the following website: http://governor.ohio.gov/GovernorsOffice/ExecutiveOrdersDirectives/tabid/105/Default.aspx.

C. MCP hereby covenants that MCP, its officers, members and employees of the MCP, shall not, prior to the completion of the work under this Agreement, voluntarily acquire any

interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of his or her functions and responsibilities under this provider agreement. MCP shall periodically inquire of its officers, members and employees concerning such interests.

D. Any such person who acquires an incompatible, compromising or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, shall immediately disclose his or her interest to ODJFS in writing. Thereafter, he or she shall not participate in any action affecting the services under this provider agreement, unless ODJFS 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, BPHPS, ODJFS.

E. No officer, member or employee of MCP shall promise or give to any ODJFS 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. No officer, member or employee of MCP shall solicit an ODJFS employee to violate any ODJFS rule or policy relating to the conduct of the parties to this agreement or to violate sections 102.03, 102.04, 2921.42 or 2921.43 of the ORC.

F. MCP hereby covenants that MCP, its officers, members and employees are in compliance with section 102.04 of the ORC and that if MCP is required to file a statement pursuant to 102.04(D)(2) of the ORC, such statement has been filed with the ODJFS in addition to any other required filings.

ARTICLE VI - NONDISCRIMINATION OF EMPLOYMENT

A. MCP 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, MCP shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry, discriminate against any citizen of this state in the employment of a person qualified and available to perform the services to which the provider agreement relates.

B. MCP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the provider agreement on account of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry.

C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5101:3-26, MCP agrees to hold all subcontractors and persons acting on behalf of MCP 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 rule 5101:3-26-05.

ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION

A. MCP agrees that all records, documents, writings or other information produced by MCP under this provider agreement and all records, documents, writings or other information used by MCP in the performance of this provider agreement shall be treated in accordance with OAC rule 5101:3-26-06. MCP must maintain an appropriate record system for services provided to members. MCP must retain all records in accordance with 45 CFR Part 74.

B. All information provided by MCP to ODJFS that is proprietary shall be held to be strictly confidential by ODJFS. Proprietary information is information which, if made public, would put MCP at a disadvantage in the market place and trade of which MCP is a part [see ORC Section 1333.61(D)]. MCP is responsible for notifying ODJFS of the nature of the information prior to its release to ODJFS. Failure to provide such prior notification is deemed to be a waiver of the proprietary nature of the information, and a waiver of any right of MCP to proceed against ODJFS for violation of this agreement or of any proprietary or trade secret laws. Such failure shall also be deemed a waiver of trade secret protection in that the MCP will have failed to make efforts that are reasonable under the circumstances to maintain the information’s secrecy. ODJFS reserves the right to require reasonable evidence of MCP's assertion of the proprietary nature of any information to be provided and ODJFS will make the final determination of whether any or all of the information identified by the MCP is proprietary or a trade secret. The provisions of this Article are not self-executing.

C. MCP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this provider agreement. MCP agrees to be bound by the same standards of confidentiality that apply to the employees of the ODJFS and the state of Ohio. The terms of this section shall be included in any subcontracts executed by MCP for services under this provider agreement. MCP 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.

ARTICLE VIII - SUSPENSION AND TERMINATION

A. This provider agreement may be suspended or terminated by the department or MCP upon written notice in accordance with the applicable rule(s) of the OAC, with termination to occur at the end of the last day of a month.

B. MCP, upon receipt of notice of suspension or termination, shall cease provision of services on the suspended or terminated activities under this provider agreement; suspend, or terminate all subcontracts relating to such suspended or terminated activities,

take all necessary or appropriate steps to limit disbursements and minimize costs, and furnish a report, as of the date of receipt of notice of suspension or termination describing the status of all services under this provider agreement.

C. In the event of suspension or termination under this Article, MCP shall be entitled to reconciliation of reimbursements through the end of the month for which services were provided under this provider agreement, in accordance with the reimbursement provisions of this provider agreement. MCP agrees to waive any right to, and shall make no claim for, additional compensation against ODJFS by reason of such suspension or termination.

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

E. When initiated by MCP on or before June 30, 2011 termination of or failure to renew the provider agreement requires written notice to be received by ODJFS at least 120 days in advance of the termination or renewal date, provided, however, that termination or non-renewal must be effective at the end of the last day of a calendar month. When initiated by the MCP after June 30, 2011, termination of or failure to renew the provider agreement requires written notice to be received by ODJFS at least 240 days in advance of the termination or renewal date, provided, however, that termination or non-renewal must be effective at the end of the last day of a calendar month. In the event of non-renewal of the provider agreement with ODJFS, if MCP is unable to provide the required number of days of notice to ODJFS prior to the date when the provider agreement expires, then the provider agreement shall be deemed extended to the last day of the month that is the required number of days from the date of the termination notice, and both parties shall, for that time, continue to fulfill their duties and obligations as set forth herein. If an MCP wishes to terminate or not renew their provider agreement for a specific region(s), ODJFS reserves the right to initiate a procurement process to select additional MCPs to serve Medicaid consumers in that region(s). ODJFS, at its discretion, may use an MCP’s termination or non-renewal of this provider agreement as a factor in any future procurement process.

ARTICLE IX - AMENDMENT AND RENEWAL

A. This writing constitutes the entire agreement between the parties with respect to all matters herein. 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. This provider agreement may be renewed one or more times by in writing signed by both parties for a period of not more than twelve months for each renewal.

C. 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 ODJFS to modify this Agreement, ODJFS shall notify MCP regarding such changes and this agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this Article of this Agreement.

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

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

ARTICLE X - LIMITATION OF LIABILITY

A. MCP agrees to indemnify and to hold ODJFS and the state of Ohio harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of MCP or its subcontractors in the fulfillment of this provider agreement or arising from this Agreement which are attributable to the MCP's own actions or omissions of those of its trustees, officers, employees, subcontractors, suppliers, third parties utilized by MCP, or joint venturers while acting under this Agreement. Such claims shall include 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, and trademarks. MCP shall bear all costs associated with defending ODJFS and the state of Ohio against these claims.

B. MCP hereby agrees to be liable for any loss of federal funds suffered by ODJFS for enrollees resulting from specific, negligent acts or omissions of the MCP or its subcontractors during the term of this agreement, including but not limited to the nonperformance of the duties and obligations to which MCP has agreed under this agreement.

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

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

ARTICLE XI - ASSIGNMENT

A. ODJFS will not allow the transfer of Medicaid members by one MCP to another MCP unless this membership has been obtained as a result of an MCP selling their entire Ohio corporation to another health plan. MCP 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 ODJFS and subject to such conditions and provisions as ODJFS may deem necessary. Any such assignments shall be submitted for ODJFS' review 120 days prior to the desired effective date. No such approval by ODJFS of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODJFS in addition to the total agreed-upon reimbursement in accordance with this agreement.

B. MCP 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 ODJFS and subject to such conditions and provisions as ODJFS may deem necessary. Any such assignments of subcontracts shall be submitted for ODJFS' review 30 days prior to the desired effective date. No such approval by ODJFS of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODJFS in addition to the total agreed-upon reimbursement in accordance with this agreement.

ARTICLE XII - CERTIFICATION MADE BY MCP

A. This agreement is conditioned upon the full disclosure by MCP to ODJFS of all information required for compliance with federal regulations as requested by ODJFS.

B. By executing this agreement, MCP certifies that no federal funds paid to MCP through this or any other agreement with ODJFS shall be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement or loan. MCP further certifies compliance with the lobbying restrictions contained in Section 1352, Title 31 of the U.S. Code, Section 319 of Public Law 101-121 and federal regulations issued pursuant thereto and contained in 45 CFR Part 93, Federal Register, Vol. 55, No. 38, February 26, 1990, pages 6735-6756. If this Agreement exceeds $100,000, MCP has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. This certification is material representation of fact upon which reliance was placed when this provider agreement was entered into.

C. By executing this agreement, MCP certifies that neither MCP nor any principals of MCP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal

agency. The MCP also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC Section 153.02 or ORC Section 125.25. The MCP also certifies that the MCP has no employment, consulting or any other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the MCP's contractual obligation with ODJFS. 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 MCP knowingly executed this certification erroneously, then in addition to any other remedies, this provider agreement shall be terminated pursuant to Article VII, and ODJFS must advise the Secretary of the appropriate federal agency of the knowingly erroneous certification.

D. By executing this agreement, MCP certifies compliance with Article V as well as agreeing to future compliance with Article V. This certification is a material representation of fact upon which reliance was placed when this contract was entered into.

E. By executing this agreement, MCP certifies compliance with the executive agency lobbying requirements of sections 121.60 to 121.69 of the ORC. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into.

F. By executing this agreement, MCP certifies that MCP is not on the most recent list established by the Secretary of State, pursuant to section 121.23 of the ORC, which identifies MCP as having more than one unfair labor practice contempt of court finding. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into.

G. By executing this agreement MCP agrees not to discriminate against individuals who have or are participating in any work program administered by a county Department of Job and Family Services (CDJFS) under Chapters 5101 or 5107 of the ORC.

H. By executing this agreement, MCP certifies and affirms that, as applicable to MCP, that no party listed or described in Division (I) or (J) of Section 3517.13 of the ORC who was actually 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 MCP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, MCP shall return to ODJFS all monies paid to MCP under this provider

agreement. The provisions of this section shall survive the expiration or termination of this provider agreement.

I. MCP agrees to refrain from promising or giving to any ODJFS 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. MCP also agrees that it will not solicit an ODJFS employee to violate any ODJFS rule or policy relating to the conduct of contracting parties or to violate sections 102.03, 102.04, 2921.42 or 2921.43 of the ORC.

J. By executing this agreement, MCP certifies and affirms that HHS, US Comptroller General or representatives will have access to books, documents, etc. of MCP.

K. By executing this agreement, MCP agrees to comply with the false claims recovery requirements of Section 6032 of The Deficit Reduction Act of 2005 (also see Section 5111.101 of the ORC).

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

M. MCP hereby represents and warrants to ODJFS that it has not provided any material assistance, as that term is defined in ORC Section 2909.33(C), to any organization identified by and included on the United States Department of State Terrorist Exclusion List and that it has truthfully answered "no" to every question on the "Declaration Regarding Material Assistance/Non-assistance to a Terrorist Organization." MCP further represents and warrants that it has provided or will provide such to ODJFS prior to execution of this Agreement. If these representations and warranties are found to be false, this Agreement is void *ab initio* and MCP shall immediately repay to ODJFS any funds paid under this Agreement.

N. By executing this agreement, MCP certifies and confirms that any performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention.

O. By executing this agreement, MCP certifies and confirms that it agrees to comply with all applicable standards orders or regulations of the Clean Air Act and Federal Water Pollution Control Act.

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 5101:3-26 (Appendix A) is hereby incorporated by reference as part of this provider agreement having the full force and effect as if specifically restated herein.

B. Appendices B through P 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.

C. In the event of inconsistence or ambiguity between the provisions of OAC Chapter 5101:3-26 and this Agreement, the provisions of OAC Chapter 5101:3-26 shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, as provided in Article IX of this provider agreement, in which case such federal or state law shall be determinative of the obligations of the parties. In the event OAC 5101:3-26 is silent with respect to any ambiguity or inconsistency, the Agreement (including Appendices B through P and any additional appendices), shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the provider agreement and the budgetary and statutory constraints of ODJFS.

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 above.

ARTICLE XVI – HEADINGS

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

The parties have executed this agreement the date first written above. The agreement is hereby accepted and considered binding in accordance with the terms and conditions set forth in the preceding statements.

MCP NAME:

BY: _____ DATE: _____
_____, PRESIDENT & CEO

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES:

BY: _____ DATE: _____
DOUGLAS E. LUMPKIN, DIRECTOR

**Ohio Department of Job and Family Services**
**Medical Assistance Provider Agreement**
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**July 1, 2010**


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## APPENDIX A

## OAC RULES 5101:3-26

The managed care program rules can be accessed electronically through the Medicaid managed care page of the ODJFS website.

# APPENDIX B

## SERVICE AREA SPECIFICATIONS

## MCP : [NAME]

**The MCP agrees to provide services to Aged, Blind or Disabled (ABD) members and/or Covered Families and Children (CFC) members residing in the following service area(s):**

| Service Area | ABD Eligible Population | CFC Eligible Population |
|---|---|---|
| Central Region | ☐ ABD | ☐ CFC |
| East Central Region | ☐ ABD | ☐ CFC |
| Northeast Region | ☐ ABD | ☐ CFC |
| Northeast Central Region | ☐ ABD | ☐ CFC |
| Northwest Region | ☐ ABD | ☐ CFC |
| Southeast Region | ☐ ABD | ☐ CFC |
| Southwest Region | ☐ ABD | ☐ CFC |
| West Central Region | ☐ ABD | ☐ CFC |

*The ABD and CFC categories of assistance are described in OAC rule 5101:3-26-02(B).

*MCPs must serve all counties in any region they agree to serve. See the next page for a list of counties in each region.

# OHIO MCP REGIONS

## Counties in the Central Region

| | | |
|---|---|---|
| Crawford | Knox | Perry |
| Delaware | Licking | Pickaway |
| Fairfield | Logan | Pike |
| Fayette | Madison | Ross |
| Franklin | Marion | Scioto |
| Hocking | Morrow | Union |

## Counties in the East Central Region

| | | |
|---|---|---|
| Ashland | Portage | Summit |
| Carroll | Richland | Tuscarawas |
| Holmes | Stark | Wayne |

## Counties in the Northeast Region

| | | |
|---|---|---|
| Ashtabula | Geauga | Lorain |
| Cuyahoga | Huron | Medina |
| Erie | Lake | |

## Counties in the Northeast Central Region

| | | |
|---|---|---|
| Columbiana | Mahoning | Trumbull |

## Counties in the Northwest Region

| | | |
|---|---|---|
| Allen | Henry | Sandusky |
| Auglaize | Lucas | Seneca |
| Defiance | Mercer | Van Wert |
| Fulton | Ottawa | Williams |
| Hancock | Paulding | Wood |
| Hardin | Putnam | Wyandot |

## Counties in the Southeast Region

| | | |
|---|---|---|
| Athens | Jackson | Muskingum |
| Belmont | Jefferson | Noble |
| Coshocton | Lawrence | Vinton |
| Gallia | Meigs | Washington |
| Guernsey | Monroe | |
| Harrison | Morgan | |

## Counties in the Southwest Region

| | | |
|---|---|---|
| Adams | Clermont | Highland |
| Brown | Clinton | Warren |
| Butler | Hamilton | |

## Counties in the West Central Region

| | | |
|---|---|---|
| Champaign | Greene | Preble |
| Clark | Miami | Shelby |
| Darke | Montgomery | |

# APPENDIX C

## MCP RESPONSIBILITIES

The MCP must meet on an ongoing basis, all program requirements specified in Appendix A, Ohio Administrative Code (OAC) Rules 5101:3-26 and the Ohio Department of Job and Family Services (ODJFS) - MCP Provider Agreement. The following are MCP responsibilities that are not otherwise specifically stated in OAC rule provisions or elsewhere in the MCP provider agreement, but are required by ODJFS.

General Provisions

1. The MCP 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 MCP must submit a current copy of their Certificate of Authority (COA) to ODJFS within 30 days of issuance by the Ohio Department of Insurance (ODI).

3. The MCP must designate the following:

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

   b. A provider relations representative for each service area included in their ODJFS provider agreement. This provider relations representative can serve in this capacity for only one service area.

4. All MCP employees are to direct all day-to-day submissions and communications to their ODJFS-designated Contract Administrator unless otherwise notified by ODJFS.

5. The MCP must be represented at all meetings and events designated by ODJFS as requiring mandatory attendance.

6. The MCP must have an administrative office located in Ohio.

7. Upon request by ODJFS, the MCP must submit information on the current status of their company's operations not specifically covered under this Agreement (for example, other product lines, Medicaid contracts in other states, National Committee for Quality Assurance [NCQA] accreditation, etc.) unless otherwise excluded by law.

8. The MCP must have all new employees trained on applicable program requirements, and represent, warrant and certify to ODJFS that such training occurs, or has occurred.

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

10. For any data and/or documentation that MCPs are required to maintain, ODJFS may request that MCPs provide analysis of this data and/or documentation to ODJFS in an aggregate format, such format to be solely determined by ODJFS.

11. The MCP is responsible for determining medical necessity for services and supplies requested for their members as specified in OAC rule 5101:3-26-03. Notwithstanding such responsibility, ODJFS retains the right to make the final determination on medical necessity in specific member situations.

12. In addition to the timely submission of medical records at no cost for the annual external quality review as specified in OAC rule 5101:3-26-07, the MCP may be required for other purposes to submit medical records at no cost to ODJFS and/or designee upon request.

13. In addition to the provisions in OAC 5101:3-26-05(B), the MCP must notify the Bureau of Policy and Health Plan Services (BPHPS) within 1 working day of becoming aware of the termination of an MCP panel provider if that provider is designated as the primary care provider (PCP) for either 100 or more of the MCP's ABD members or 500 or more of the MCP's CFC members, or a combined total of 500 or more of the MCP's members if the provider is serving both the ABD and CFC populations.

14. Upon request by ODJFS, MCPs may be required to provide written notice to members of any significant change(s) affecting contractual requirements, member services or access to providers.

15. MCPs may elect to provide services that are in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Before MCPs notify potential or current members of the availability of these services, they must first notify ODJFS and advise ODJFS of such planned services availability. If an MCP elects to provide additional services, the MCP must ensure to the satisfaction of ODJFS 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 ODJFS.

a. MCPs are **required** to make transportation available to any member requesting transportation when they **must** travel thirty (30) miles or more from their home to receive a medically-necessary Medicaid-covered service provided by the MCP pursuant to OAC rule 5101:3-26-03 and Appendix G of the Agreement. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.

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

c. MCPs must give ODJFS and members ninety (90) days prior notice when decreasing or ceasing any additional benefit(s). When it is beyond the control of the MCP, as demonstrated to ODJFS' satisfaction, ODJFS must be notified within one (1) working day.

16. MCPs 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. MCPs 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.

17. Upon request, the MCP will provide members and potential members with a copy of their practice guidelines.

18. The MCP is responsible for promoting the delivery of services in a culturally competent manner, as solely determined by ODJFS, to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds.

All MCPs must comply with the requirements specified in OAC rules 5101:3-26-03.1, 5101:3-26-05(D), 5101:3-26-05.1(A), 5101:3-26-08 and 5101:3-26-08.2 for providing assistance to LEP members and eligible individuals. In addition, MCPs must provide written translations of certain MCP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

a. When 10% or more of the eligible individuals in the MCP's service area have a common primary language other than English, the MCP must translate all ODJFS-approved marketing materials into the primary language of that group. The MCP must monitor changes in the eligible population on an ongoing basis and conduct an assessment no less often than annually to determine which, if any, primary language groups meet the 10% threshold for the eligible individuals in each service area. When the 10% threshold is met, the MCP must report this information to ODJFS, in a format as requested by ODJFS, translate their marketing materials, and make these marketing materials available

to eligible individuals. MCPs must submit to ODJFS, upon request, their prevalent non-English language analysis of eligible individuals and the results of this analysis.

b. When 10% or more of an MCP's members in the MCP's service area have a common primary language other than English, the MCP must translate all ODJFS-approved member materials into the primary language of that group. The MCP must monitor their membership and conduct a quarterly assessment to determine which, if any, primary language groups meet the 10% threshold. When the 10% threshold is met, the MCP must report this information to ODJFS, in a format as requested by ODJFS, translate their member materials, and make these materials available to their members. MCPs must submit to ODJFS, upon request, their prevalent non-English language member analysis and the results of this analysis.

19. The MCP must utilize a centralized database which records the special communication needs of all MCP members (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment) and the provision of related services (i.e., MCP materials in alternate format, oral interpretation, oral translation services, written translations of MCP materials, and sign language services). This database must include all MCP member primary language information (PLI) as well as all other special communication needs information for MCP members, as indicated above, when identified by any source including but not limited to ODJFS, the Managed Care Enrollment Center (MCEC), MCP staff, providers, and members. This centralized database must be readily available to MCP staff and be used in coordinating communication and services to members, including the selection of a PCP who speaks the primary language of an LEP member, when such a provider is available. MCPs must share specific communication needs information with their providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable. MCPs must submit to ODJFS, upon request, detailed information regarding the MCP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the MCP as well as those services reported to the MCP which were arranged by the provider).

Additional requirements specific to providing assistance to hearing-impaired, vision-impaired, LRP, and LEP members and eligible individuals are found in OAC rules 5101:3-26-03.1, 5101:3-26-05(D), 5101:3-26-05.1(A), 5101:3-26-08, and 5101-3-26-08.2.

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

21. Pursuant to OAC rules 5101:3-26-08 and 5101:3-26-08.2, the MCP is responsible for ensuring that all MCP marketing and member materials are prior approved by ODJFS before being used or shared with 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 5101:3-26-08.4. Marketing and member materials are defined as follows:

a. Marketing materials are those items produced in any medium, by or on behalf of an MCP, including gifts of nominal value (i.e., items worth no more than $15.00), which can reasonably be interpreted as intended to market to eligible individuals.

b. Member materials are those items developed, by or on behalf of an MCP, to fulfill MCP 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 MCP and which do not include any reference to the MCP are not considered to be member materials.

c. All MCP marketing and member materials must represent the MCP in an honest and forthright manner and must not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODJFS.

d. All MCP marketing cannot contain any assertion or statement (whether written or oral) that the MCP is endorsed by the Centers for Medicare and Medicaid Services (CMS), the Federal or State government or similar entity.

e. MCPs must establish positive working relationships with the County Department of Job and Family Services (CDJFS) offices and must not aggressively solicit from local Directors, MCP County Coordinators, or other staff. Furthermore, MCPs are prohibited from offering gifts to CDJFS offices or MCEC staff, as these may influence an individual's decision to select a particular MCP.

f. MCP marketing representatives and other MCP 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 MCPs, as all enrollment activities must be completed by the MCEC.

22. Advance Directives - All MCPs must comply with the requirements specified in 42 CFR 422.128. At a minimum, the MCP 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.

b. Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCP to ensure that the MCP:

i. Provides written information to all adult members concerning:

a. The member's rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. In meeting this requirement, MCPs must utilize the current version of form JFS 08095 entitled *You Have the Right*, or include the text from JFS 08095 in their ODJFS-approved member handbook.

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

c. Any changes in state law regarding advance directives as soon as possible, but no later than ninety (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 staff concerning the MCP's policies and procedures on advance directives;

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

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

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

23. New Member Materials - Pursuant to OAC rule 5101:3-26-08.2(B)(3), MCPs must provide to each member or assistance group, as applicable, an MCP identification (ID) card, a new member letter, a member handbook, provider panel information, and information on advance directives, as specified by ODJFS.

a. MCPs must use the model language specified by ODJFS for the new member letter.

b. The ID card and new member letter must be mailed together to the member via a method that will ensure their receipt prior to the member's effective date of coverage.

c. MCPs may provide provider panel information to new members via the MCP's website only if the members have requested that the provider panel information be provided via the website as reported to the MCP on the consumer contact record (CCR). If a new member did not request the information be provided via the website as reported on the CCR, including a new member assigned to the MCP, the MCP must provide a printed provider directory to the new member as specified in 24.d. of this Appendix.

d. The member handbook, provider directory, if applicable and advance directives information may be mailed to the member separately from the ID card and new member letter. MCPs will meet the timely receipt requirement for these materials if they are mailed to the member within twenty-four (24) hours of the MCP receiving the ODJFS produced membership roster (MR). This is provided the materials are mailed via a method with an expected delivery date of no more than five (5) days. If the member handbook, provider directory, and advance directives information are mailed separately from the ID card and new member letter and the MCP is unable to mail the materials within twenty-four (24) hours, the member handbook, provider directory, and advance directives information must be mailed via a method that will ensure receipt by no later than the effective date of coverage. If the MCP mails the ID card and new member letter with the other materials (e.g., member handbook, provider directory, and advance directives), the MCP must ensure that <u>all</u> materials are mailed via a method that will ensure their receipt <u>prior</u> to the member's effective date of coverage.

e. MCPs must designate two (2) MCP staff members to receive a copy of the new member materials on a monthly basis in order to monitor the timely receipt of these materials. At least one of the staff members must receive the materials at their home address.

f. The MCP ID card must contain pharmacy information, as prescribed by ODJFS.

24. <u>Call Center Standards</u> - The MCP must provide assistance to members through a member services toll-free call-in system pursuant to OAC rule 5101:3-26-08.2(A)(1). MCP member services staff must be available nationwide to provide assistance to members through the toll-free call-in system every Monday through Friday, at all times during the hours of 7:00 am to 7:00 pm Eastern Time, except for the following major holidays:

- New Year's Day
- Martin Luther King's Birthday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day
- 2 optional closure days: These days can be used independently or in combination with any of the major holiday closures, but cannot both be used within the same closure period. Before announcing any optional closure dates to members and/or

staff, MCPs must receive ODJFS prior-approval which verifies that the optional closure days meet the specified criteria.

If a major holiday falls on a Saturday, the MCP member services line may be closed on the preceding Friday. If a major holiday falls on a Sunday, the member services line may be closed on the following Monday. MCP member services closure days must be specified in the MCP's member handbook, member newsletter, or other some general issuance to the MCP's members at least thirty (30) days in advance of the closure.

The MCP must also provide access to medical advice and direction through a centralized twenty-four-hour, seven day (24/7), toll-free call-in system, available nationwide, pursuant to OAC rule 5101:3-26-03.1(A)(6). The 24/7 call-in system must be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs).

MCPs 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. By the 10th of each month, MCPs must self-report their prior month performance in these three areas for their member services and 24/7 hour toll-free call-in systems to ODJFS. If an MCP has separate telephone lines for different Medicaid populations, the MCP must report performance for each individual line separately. ODJFS will inform the MCPs of any changes/updates to these URAC call center standards.

MCPs are not permitted to delegate grievance/appeal functions [OAC rule 5101:3-26-08.4(A)(9)]. Therefore, 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.

MCPs must not use, any offshore programming or call center services in fulfilling the program requirements. In no situation may PHI be transferred to any location outside the United States or its territories.

25. Notification of Optional MCP Membership - In order to comply with the terms of the ODJFS State Plan Amendment for the managed care program (i.e., 42 CFR 438.50), MCPs in mandatory membership service areas must inform new members that MCP membership is optional for certain populations.

Specifically, MCPs must inform any applicable ABD or CFC pending member or member that the following population is not required to select an MCP in order to receive their Medicaid healthcare benefit and what steps they need to take if they do not wish to be a member of an MCP:

- Indians who are members of federally-recognized tribes, except as permitted under 42 CFR 438.50(d)(2).

Additionally, MCPs must inform any applicable CFC pending member or member that the following populations are not required to select an MCP in order to receive their Medicaid healthcare benefit and what steps they need to take if they do not wish to become a member of an MCP:

- Children under 19 years of age who are:
  - Eligible for Supplemental Security Income under title XVI;
  - In foster care or other out-of-home placement;
  - Receiving foster care or adoption assistance;
  - 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.

26. Privacy Compliance Requirements - The Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations at 45 CFR.164.502(e) and 164.504(e) require ODJFS to have agreements with MCPs as a means of obtaining satisfactory assurance that the MCPs will appropriately safeguard all personal identified health information. Protected Health Information (PHI) (45 C.F.R. 160.103). is information received from or on behalf of ODJFS that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 CFR 164.501 and any amendments thereto. MCPs must comply with any other applicable Federal and State laws (such as Title VI of the Civil rights Act of 1964, etc.) and other laws regarding privacy and confidentiality, as such may be applicable to this Agreement. MCP is a business associate of the Office of Ohio Health Plans, ODJFS and agrees to the following:

a. The MCP shall not use or disclose PHI other than is permitted by this Agreement or as otherwise required under HIPAA regulations or other applicable law.

b. The MCP shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf the BPHPS.

c. The MCP shall report to ODJFS any unauthorized use or disclosure of PHI of which it becomes aware. Any breach by the MCP or its representatives of PHI standards shall be immediately reported to the BPHPS. MCPs must provide documentation of the breach and complete all actions ordered by the HIPAA compliance officer. The MCP shall mitigate any adverse effects of such a breach of confidentiality to the greatest extent possible.

d. The MCP shall ensure that all its agents and subcontractors agree to these same PHI conditions and restrictions that apply to the MCP with respect to the use or disclosure of PHI.

e. The MCP shall make available to ODJFS such information as ODJFS may require to fulfill its obligations to provide access to, provide a copy of, and account for disclosures 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 C.F.R. 164.524 and 164.528 and any amendments thereto.

f. The MCP shall make PHI available to ODJFS so that ODJFS may fulfill its obligations pursuant to HIPAA to amend the information. As directed by ODJFS, the MCP shall also incorporate any amendments into the information held by the MCP and shall ensure incorporation of any such amendments into information held by the MCP's agents or subcontractors.

g. The MCP shall make PHI disclosure information available for accounting as required by law.

h. The MCP shall make available to ODJFS and to the Secretary of the U.S. Department of Health and Human Services (HHS) any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from ODJFS, or created or received by the MCP on behalf of ODJFS. Such access is for the purpose of determining ODJFS' compliance with HIPAA, regulations promulgated by the United States Department of Health and Human Services, and any amendment thereto.

i. Upon termination of their agreement with ODJFS, the MCPs, at ODJFS' option, shall return to ODJFS, or destroy, all PHI in its possession, and keep no copies of the information, except as requested by ODJFS or required by law. If the MCP, its agent(s), or subcontractor(s) destroy any PHI, then the MCP will provide to ODJFS documentation evidencing such destruction. Any PHI retained by the MCP shall continue to be extended the same protections set forth in this Section and HIPAA regulations for as long as it is maintained.

j. In the event of material breach of the MCP's obligations under this article, ODJFS may immediately terminate this Agreement as set forth in Article VIII. Termination of this Agreement shall 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.

27. Electronic Communications – MCPs are required to purchase/utilize Transport Layer Security (TLS) for all e-mail communication between ODJFS and the MCP. The MCP's e-mail gateway must be able to support the sending and receiving of e-mail using TLS and the MCP's gateway must be able to enforce the sending and receiving of email via TLS.

28. MCP Membership Acceptance, Documentation and Reconciliation

a. Managed Care Enrollment Center (MCEC) Contractor - The MCP shall provide to the

MCEC ODJFS prior-approved MCP materials and directories for distribution to eligible individuals who request additional information about the MCP.

b. Reconciliation of Membership and Premiums - The MCP shall reconcile member data as reported on the MCEC produced consumer contact record (CCR) with the MR and report to the ODJFS any difficulties in interpreting or reconciling information received. Membership reconciliation questions must be identified and reported to the ODJFS prior to the first of the next month. The MCP shall reconcile membership with premium payments reported on the monthly remittance advice (RA). Upon MITS implementation, ODJFS will provide written guidance to MCPs regarding the required use of the 834C daily file.

The MCP shall work directly with the ODJFS, or other ODJFS-identified entity, resolve any difficulties in interpreting or reconciling premium information. Premium reconciliation questions must be identified within thirty (30) days of receipt of the RA unless the reconciliation concerns a newborn. Newborn related reconciliation questions must be identified within 460 days from the newborn's date of birth. Reconciliation data must be submitted in the format specified by ODJFS.

c. Monthly Premiums and Delivery Payments - The MCP must be able to receive monthly premiums and delivery payments in a method specified by ODJFS.

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

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

When an MCP learns that a new member who was previously on Medicaid fee-for-service was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall notify the hospital/ inpatient facility and treating providers that the MCP may not be the payer. The MCP shall work with hospital/inpatient facility, treating providers and the ODJFS to assure that discharge planning assures continuity of care and accurate payment. When the enrolling MCP learns of a deferment-eligible hospitalization, the MCP shall notify the ODJFS **and** request the deferment within six (6) months of the member's effective date.-

e. Just Cause Requests - As specified by ODJFS, the MCP shall assist in resolving member-initiated requests affecting membership.

f. Newborn Notifications – MCP membership for newborns will be in accordance with rule 5101:3-26-02.

In order to encourage the timely addition and authorization for Medicaid and enrollment in the MCP, the MCP must provide notification of the birth to the CDJFS and the ODJFS.

The MCP must notify the CDJFS and provide at a minimum the mother's name, social security number, 10 digit CRIS-E case number, 12 digit recipient ID, county and the newborn's name, gender, and date of birth, unless the CDJFS and MCP have agreed to a different minimum set of information to be transmitted for the CDJFS newborn notification. This information must be sent within five working days of the birth, or immediately upon learning of the birth. The information must be sent again at sixty days from the date of birth if the MCP has not received confirmation by ODJFS of a newborn's MCP membership via the membership roster(s).

The MCP must report to ODJFS by the fifth of each month, information on each newborn that has reached 90 days of age and has not been added or authorized to the mother's case. Report(s) must be in the format(s) specified by ODJFS.

g. Eligible Individuals - If an eligible individual contacts the MCP, the MCP must provide any MCP-specific managed care program information requested. The MCP must not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/transitioning health care services, MCPs shall provide an assurance that all MCPs must cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.

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

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

i. Transition of Fee-For-Service (FFS) Members - Providing care coordination for prescheduled health services, access to preventive and specialized care, care management, member services, and education with minimal disruption to members' established relationships with providers and existing care treatment plans, is critical for members transitioning from FFS to managed care. MCPs are not required to allow the continuation of services identified in C.29.i.b and C.29.i.c for a member who resides in a service area in which enrollment in an MCP is not required and the member voluntarily chooses to enroll in the MCP.

a. ABD Member Transition Plan - For FFS members who are transitioning to managed care as an ABD member, MCPs must develop and implement a transition plan that outlines how the MCP will effectively address the unique care coordination issues of members in their first three months of MCP membership and how the various MCP departments will coordinate and share information regarding these new members. The transition plan must include at a minimum:

i. An effective outreach process to identify each new member's existing and/or potential health care needs that results in a new member profile that includes, but is not limited to identification of:

a. Health care needs, including those services received through state sub-recipient agencies [e.g., the Ohio Department of Mental Health (ODMH), the Ohio Department of Developmental Disabilities (DODD) effective October 5, 2009), the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Aging (ODA)];

b. Existing sources of care (i.e., primary physicians, specialists, case manager(s), ancillary and other care givers); and

c. Current care therapies for all aspects of health care services, including scheduled health care appointments, planned and/or approved surgeries (inpatient or outpatient), ancillary or medical therapies, prescribed drugs, home health care services, private duty nursing (PDN), scheduled lab/radiology tests, necessary durable

medical equipment, supplies and needed/approved transportation arrangements.

ii. Strategies for how each new member will obtain care therapies from appropriate sources of care as an MCP member. The MCP's strategies must include at a minimum activities specified in Appendix C.29.i.b, as applicable.

b. ABD and CFC Member Continuation of Services from Out-of-Panel Providers - Allowing their new members that are transitioning from FFS to an MCP as an ABD or CFC member, to receive services from out-of-panel providers if the member or provider contacts the MCP to discuss the scheduled health services in advance of the service date and one of the following applies:

i. The CFC member has appointments within the initial month of MCP membership with specialty physicians that were scheduled prior to the effective date; or, the ABD member has appointments within the initial three months of MCP membership with a primary care provider or specialty physician that was scheduled prior to the effective date of membership;

ii. The CFC or ABD member is in her third trimester of pregnancy and has an established relationship with an obstetrician and/or delivery hospital;

iii. The CFC or ABD member has been scheduled for an inpatient or outpatient surgery and has been prior-approved and/or pre-certified pursuant to OAC rule 5101:3-2-40 (surgical procedures would also include follow-up care as appropriate);-

iv. The CFC or ABD member is receiving ongoing chemotherapy or radiation treatment; or

v. The ABD member has been released from the hospital within thirty (30) days prior to MCP enrollment and is following a treatment plan.
If contacted by the member, the MCP must contact the provider's office as expeditiously as the situation warrants to confirm that the service(s) meets the above criteria.

c. ABD and CFC Member Continuation of Homecare Services -Allowing their new members that are transitioning from FFS to continue receiving home care services (i.e., nursing, aide, and skilled therapy services) and private duty nursing (PDN) services if the member or provider contacts the MCP to discuss the health services in advance of the service date. These services must be covered from the date of the member or provider contact at the current service level, and with the current provider, whether a panel or out-of-panel provider, until the MCP conducts a

medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1. As soon as the MCP becomes aware of the member's current home care services, the MCP must initiate contact with the current provider and member as applicable to ensure continuity of care and coordinate a transfer of services to a panel provider, if appropriate.

d. ABD and CFC Member FFS Authorizations - Honoring any current FFS prior authorization to allow their new members that are transitioning from FFS to receive services from the authorized provider, whether a panel or out-of-panel provider, for the following approved services:

i. An organ, bone marrow, or hematapoietic stem cell transplant pursuant to OAC rule 5101:3-2-07.1 and 2.b.v of Appendix G;

ii. Dental services that have not yet been received;

iii. Vision services that have not yet been received;

iv. Durable medical equipment (DME) that has not yet been received. Ongoing DME services and supplies are to be covered by the MCP as previously-authorized until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1.

v. Private Duty Nursing (PDN) services. PDN services must be covered at the previously-authorized service level until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1.

As soon as the MCP becomes aware of the member's current FFS authorization approval, the MCP must initiate contact with the authorized provider and member as applicable to ensure continuity of care. The MCP must implement a plan to meet the member's immediate and ongoing medical needs and coordinate the transfer of services to a panel provider, if appropriate. For organ, bone marrow or hematapoietic stem cell transplants, MCPs must receive prior approval from ODJFS to transfer services to a panel provider.

When an MCP medical necessity review results in a decision to reduce, suspend, or terminate services previously authorized by FFS Medicaid, the MCP must notify the member of their state hearing rights no less than 15 calendar days prior to the effective date of the MCP's proposed action, per OAC rule 5101:3-26-08.4.

e. Out-of-Panel Provider Reimbursement - Reimbursing out-of-panel providers that agree to provide the transition services at 100% of the current Medicaid FFS provider rate for the service(s) identified in Section 29.i. (b, c, and d) of this appendix.

f. Documentation of services - Documenting the provision of transition of services identified in Section 29.i. (b, c, and d) of this appendix as follows:

i. For non-panel providers, notification to the provider confirming the provider's agreement/disagreement to provide the service and accept 100% of the current Medicaid FFS rate as payment. If the provider agrees, the distribution of the MCP's materials as outlined in Appendix G.3.iv.d.

ii. Notification to the member of the non-panel provider's agreement /disagreement to provide the service. If the provider disagrees, notification to the member of the MCP's availability to assist with locating a provider as expeditiously as the member's health condition warrants.

iii. For panel providers, notification to the provider and member confirming the MCP's responsibility to cover the service.

MCPs must use the ODJFS-specified model language for the provider and member notices and maintain documentation of all member and/or provider contacts relating to such services.

g. ABD Transition of Care for prescription drugs administered in a provider setting
Implementing a transition of care process that prevents access problems for ABD new members that are transitioning from Medicaid FFS. Such a process would involve the MCP covering one time without prior authorization (PA) a prescription drug administered in a provider setting that does not require PA by FFS. For new members that are transitioning from FFS the MCP must educate the member about how to continue to access the service before the MCP may implement PA requirements for the administration of the prescription drug. The MCP's transition process must be based on the following:

i. The MCP covers without PA for at least the initial thirty (30) days of the member's MCP membership all prescription~~s~~ drugs administered in the provider setting that do not require PA by Medicaid FFS.

ii. The MCP may require subsequent PA once the MCP has educated the member that further administration of the drug will require PA be ODJFS-approved. Verbal member education may be done in place of written education but must contain the same information as a written notice.

MCPs must receive ODJFS approval prior to implementing their transition of care drug PA process.

h. ABD Antipsychotic Medications - Covering antipsychotic medications for ABD new members as well as current members as stipulated in Appendix G.3.iv.a.i.

29. Health Information System Requirements - The ability to develop and maintain information management systems capacity is crucial to successful plan performance. ODJFS therefore requires MCPs 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), each MCP 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 MCP membership terminations for other than loss of Medicaid eligibility.

ii. As required by 42 CFR 438.242(b)(1), each MCP 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), each MCP 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), each MCP must make all collected data available upon request by ODJFS or CMS.

v. Acceptance testing of any data that is electronically submitted to ODJFS is required:

a. Before an MCP may submit production files;
b. Whenever an MCP changes the method or preparer of the electronic media; and/or
c. When the ODJFS determines an MCP's data submissions have an unacceptably high error rate.

MCPs that change or modify information systems that are involved in producing any type of electronically submitted files, either internally or by changing vendors, are required to submit to ODJFS for review and

approval a transition plan including the submission of test files in the ODJFS-specified formats. Once an acceptable test file is submitted to ODJFS, as determined solely by ODJFS, the MCP can return to submitting production files. ODJFS will inform MCPs in writing when a test file is acceptable. Once an MCP's new or modified information system is operational, that MCP 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. ODJFS reserves the right to verify any MCP's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period. Penalties for noncompliance with this requirement are specified in Appendix N of the Agreement, *Compliance Assessment System*.

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

(i) Claims Adjudication

The MCP 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 (30) days of a request. MCPs must inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information must be initiated by the MCP and not only in response to provider requests.

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

(ii) The MCP 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 MCP member's retroactive termination of coverage from the MCP, unless the MCP is directed to do so by CMS, ODJFS, or applicable state or federal law and regulation. However, the preceding sentence does not prohibit the MCP or ODJFS 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 MCP must have policies providing that, upon discovery of claims payment systemic errors that resulted in incorrectly underpaying or denying claims, the MCP 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 MCP 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 MCP shall notify ODJFS of the error and shall specify its process and timeline for corrective action, unless the MCP corrects the payments within 60 days from the date of identification of the error. The MCP'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 MCP or by any provider. If the error is not a claims payment systemic error, the MCP shall correct the payments within 60 days from the date of identification of the error.

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

(v) Electronic Data Interchange
The MCP 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 MCP shall be implemented in conformance with the appropriate version of the transaction implementation
guide, as specified by applicable federal rule or regulation.

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

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

ASC X12 834 - Benefit Enrollment and Maintenance.

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

(vi) Documentation of Compliance with Mandated EDI Standards
The capacity of the MCP and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions in compliance with standards and effective dates mandated by HIPAA must be demonstrated, to the satisfaction of ODJFS, as outlined below.

(vii) Verification of Compliance with HIPAA (Health Insurance Portability and

Accountability Act of 1996)
MCPs shall comply with the transaction standards and code sets for sending and receiving applicable transactions as specified in 45 CFR Part 162 – Health Insurance Reform: Standards for Electronic Transactions (HIPAA regulations). In addition the MCP must enter into the appropriate trading partner agreement and implemented standard code sets. If the MCP has obtained third-party certification of HIPAA compliance for any of the items listed below, that certification may be submitted in lieu of the MCP'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 5.1)
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 ODJFS
MCPs must complete and submit an EDI trading partner agreement in a format specified by the ODJFS. Submission of the copy of the trading partner agreement prior to entering into this Agreement may be waived at the discretion of ODJFS; if submission prior to entering into this Agreement is waived, the trading partner agreement must be submitted at a subsequent date determined by ODJFS.

Noncompliance with the EDI and claims adjudication requirements will result in the imposition of penalties, as outlined in Appendix N of the Agreement, *Compliance Assessment System*.

c. Encounter Data Submission Requirements (will change according to MITS implementation schedule)

<u>General Requirements</u>

Each MCP must collect data on services furnished to members through an encounter data system and must report encounter data to the ODJFS. MCPs are required to submit this data electronically to ODJFS on a monthly basis in the following standard formats:

- Institutional Claims - UB92 flat file
- Noninstitutional Claims - National standard format
- Prescription Drug Claims - NCPDP, if applicable

ODJFS relies heavily on encounter data for monitoring MCP performance. The ODJFS uses encounter data to measure clinical performance, conduct access and utilization reviews, reimburse MCPs for newborn deliveries and aid in setting MCP capitation rates. For these reasons, it is important that encounter data is timely, accurate, and complete. Data quality, performance measures, and standards are described in the Agreement.

An encounter represents all of the services, including medical supplies and medications, provided to a member of the MCP by a particular provider, regardless of the payment arrangement between the MCP and the provider. For example, if a member had an emergency department visit and was examined by a physician, this would constitute two encounters, one related to the hospital provider and one related to the physician provider. However, for the purposes of calculating a utilization measure, this would be counted as a single emergency department visit. If a member visits their PCP and the PCP examines the member and has laboratory procedures done within the office, then this is one encounter between the member and their PCP.

If the PCP sends the member to a lab to have procedures performed, then this is two encounters; one with the PCP and another with the lab. For pharmacy encounters, each prescription filled is a separate encounter.

Encounters include services paid for retrospectively, through FFS payment arrangements, and prospectively, through capitated arrangements. Only encounters with services (line items) that are paid by the MCP, fully or in part, and for which no further payment is anticipated, are acceptable encounter data submissions. Immunization services submitted to the MCP must be submitted to ODJFS if these services were paid for by another entity (e.g., free vaccine programs).

All other services that are unpaid or paid in part and for which the MCP anticipates further payment (e.g., unpaid services rendered during a delivery of a newborn) may not be submitted to ODJFS until they are paid. Penalties for noncompliance with this requirement are specified in Appendix N of the Agreement, *Compliance Assessment System*. Note: upon implementation of MITS, unpaid encounters will be required to be submitted, as prescribed in ODJFS' Encounter Data Specifications.

<u>Acceptance Testing</u>
The MCP must have the capability to report all elements in the Minimum Data Set as set forth in the ODJFS Encounter Data Specifications and must submit a test file in the ODJFS-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 30.a.v. of this Appendix.

Encounter Data File Submission Procedures

A certification letter must accompany the submission of an encounter data file in the ODJFS-specified medium. The certification letter must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO.

Timing of Encounter Data Submissions

ODJFS recommends that MCPs submit encounters no more than thirty-five (35) days after the end of the month in which they were paid (e.g., claims paid in January are due March 5). For inclusion in data quality measures, performance measures, and rate setting, MCPs must submit files in the ODJFS-specified medium by the schedule specified in the ODJFS Encounter Data Specifications.

d. IDSS Data Submission and Audit Report Requirements

In accordance with 42 CFR 438.600, each MCP must submit a signed data certification letter to ODJFS attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODJFS. Each MCP must also submit to ODJFS a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODJFS.

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

e. Information Systems Review

ODJFS or its designee may review the information system capabilities of each MCP, before ODJFS enters into a provider agreement with a new MCP, when a participating MCP undergoes a major information system upgrade or change, when there is identification of significant information system problems, or at ODJFS' discretion. Each MCP must participate in the review. The review will assess the extent to which MCPs are 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. ODJFS or its designee will:

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

ii. Review the completed ISCA and accompanying documents;

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

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

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

vi. Examine MCP processes for data transfers;

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

viii. Review MCP 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 MCP.

30. Delivery Payments – CFC Members Only (File submission requirements will change according to MITS implementation schedule)

MCPs will be reimbursed for paid CFC member deliveries that are identified in the submitted encounters using the methodology outlined in the *ODJFS Delivery Payment and Reporting Procedures document*. The delivery payment represents the facility and professional service costs associated with the delivery event and postpartum care that is rendered in the hospital immediately following the delivery event; no prenatal or neonatal experience is included in the delivery payment.

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

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

If a physician and a hospital encounter is found for the same delivery, only one payment will be made. The same is true for multiple births; if multiple delivery encounters are submitted, only one payment will be made. The method for reimbursing for deliveries includes the delivery of stillborns where the MCP incurred costs related to the delivery.

Rejections

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

Timing of Delivery Payments

MCPs will be paid monthly for deliveries. For example, payment for a delivery encounter submitted with the required encounter data submission in March, will be reimbursed in March.

This payment will be a part of the weekly update (adjustment payment) that is in place currently. The third weekly update of the month will include the delivery payment. The remittance advice is in the same format as the capitation remittance advice which is sent once each month.

Updating and Deleting Delivery Encounters

The process for updating and deleting delivery encounters is handled differently from all other encounters. See the *ODJFS Encounter Data File Submission and Specifications* for detailed instructions on updating and deleting delivery encounters.

The process for deleting delivery encounters can be found on page 35 of the UB-92 technical specifications (record/field 20-7) and page III-47 of the NSF technical specifications (record/field CA0-31.0a).

Auditing of Delivery Payments

A delivery payment audit will be conducted periodically. If medical records do not substantiate that a delivery occurred related to the payment that was made, then ODJFS will recoup the delivery payment from the MCP. Also, if it is determined that the encounter which triggered the delivery payment was not a paid encounter, then ODJFS will recoup the delivery payment.

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

32. MCPs must receive prior written approval from ODJFS before adding any information to their website that would require ODJFS prior approval in hard copy form (e.g., provider listings, member handbook information).

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

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

35. Information Required for MCP Websites

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

b. On-line Member Website - MCPs 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 return e-mail or phone call). MCP responses to questions or comments must be made within one working day of receipt. MCP responses to grievances and appeals must adhere to the timeframes specified in OAC rule 5101:3-26-08.4. The member website must be regularly updated to include the most current ODJFS-approved materials, although this website must not be the only means for notifying members of new and/or revised MCP information (e.g., change in holiday closures, changes in additional benefits, and revisions to approved member materials).

The MCP 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) MCP contact information, including the MCP's toll-free member services phone number, service hours, and closure dates; (2) a list of counties covered in the MCP's service area; (3) the ODJFS-approved MCP member handbook, recent newsletters and announcements; (4) the MCP's on-line provider directory as referenced in section 36(a) of this appendix; and (5) a list of services requiring PA. MCPs must ensure that all website member information and materials are clearly labeled for CFC members and/or ABD members, as applicable. ODJFS may require MCPs to include additional information on the member website as needed.

c. On-line Provider Website – MCPs must have a secure internet-based website for contracting providers through which providers can confirm a consumer's enrollment and through which providers can submit and receive responses to prior authorization requests (an e-mail process is an acceptable substitute if the website includes the MCP's e-mail address for such submissions).

The MCP 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) MCP contact information, including the MCP's designated contact for provider issues; (2) a list of counties covered in the MCP's service area; (3) the MCP's provider manual including the MCP's claims submission process, as well as a list of services requiring PA, recent newsletters and announcements; (4) the MCP'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 MCP; (5) the MCP's on-line provider directory as referenced in section 36(a) of this appendix; (6) an explanation of how members are to access prescribed drugs and supplies; and (7) a list of medications administered in a provider setting that require PA by the MCP. MCPs must ensure that all website information and materials are clearly labeled for CFC members and/or ABD members, as applicable. ODJFS may require MCPs to include additional information on the provider website as needed.

36. PCP Feedback – The MCP 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 MCP for activities such as provider performance improvement projects that include incentive programs or the development of quality improvement programs.

37. Coordination of Benefits - When a claim is denied due to third party liability, the MCP 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 third party liability information received from the ODJFS.

38. MCP submissions with due dates that fall on a weekend or holiday are due the next business day.

39. Trial Member Level Incentive Programs - The MCP must submit a description of a proposed trial member-level incentive program to ODJFS for review and approval prior to implementation. A trial member level incentive program is defined as a time limited monetary or non-monetary reward offered to a member who complies with the intended goals of the program as outlined by the MCP (e.g., recommended health screenings) in the submission. The incentive must not be considered a medically-necessary Medicaid-covered service or an additional benefit as offered in the MCP's Member Handbook.

The MCP should refer to the Guidance Document for Managed Care Plan Submission for Trial Member Level Incentive Programs for additional clarification.

40. MCPs must subscribe to the ODJFS distribution lists for notification of all 1) OAC rule clearances, and 2) final rules published with medical assistance letters (MALs), Medicaid handbook transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. Rule clearances and MALs/MHTLs are managed by separate ODJFS entities. MCPs are solely responsible for submitting their names and email addresses to the appropriate ODJFS distribution lists and are also responsible for ensuring the validity of any e-mail addresses maintained on those distribution lists.

41. Transfer of Protected Health Information to ODJFS Fee-For-Service Pharmacy Benefit Manager

Effective February 1, 2010, ODJFS carved out Pharmacy Benefits from the benefits provided by MCPs to MCP members, and ODJFS has contracted with ACS to serve as the pharmacy benefits manager for ODJFS with respect to the management, provision and payment of Pharmacy Benefits ("the PBM Agreement").

In order to compile, analyze, prepare and file HEDIS reports, MCP requires certain ongoing data related to the carved out Pharmacy Benefits provided under the PBM Agreement on and after February 1, 2010 to MCP members.

ODJFS and the MCP are covered entities under the Health Insurance Portability and Accountability Act of 1996, and ODJFS asserts that both ACS and MCP are Business Associates of ODJFS, as defined in the Privacy Regulations, and each of ACS and MCP has executed a Business Associate Agreement directly with ODJFS in accordance with the Health Insurance Portability and Accountability Act of 1996 and the Privacy Regulations.

ODJFS instructed ACS to provide the data required to compile, analyze, prepare and file HEDIS reports to MCP. The data to be transferred includes Protected Health Information (PHI) as defined in 45 C.F.R. Parts 160 and 164 ("Privacy Regulations").

Data shall be transferred in electronic format and is limited to the data fields set forth in the data transfer document that was jointly developed by ODJFS, ACS, and the MCPs. ACS shall transfer such information for a period of time necessary for the MCP to meet its contractual duties under this agreement. ODJFS represent 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 ACS and is currently effective, and will remain in effect for the Term of this Agreement.

42. Healthchek Services

a. Informing Members About Healthchek - In addition to the Healthchek requirements specified in OAC rules 5101:3-26-03(H)(13) and 5101:3-26-08.2(B)(4)(i), the MCP must:

i Provide members with accurate information in the member handbook regarding Healthchek, Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. MCPs member handbooks, must be provided to members within the time frames specified in 23.d. of this Appendix, and must include verbatim the model language developed by ODJFS. 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 individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document entitled "Recommendations for Preventive Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics;

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.

ii. Provide the above Healthchek information on the MCP's member website specified in 35.b. of this Appendix.

b. Informing Providers about Healthchek -- In addition to the Healthchek requirements specified in OAC rule 5101:3-26-05.1(A)(13), the MCP 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 5101: 3-14;

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 MCP's provider website as specified in 35.c. of this Appendix.

43. As outlined in OAC rule 5101:3-26-05(D)(10), MCP 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).

# APPENDIX D

## ODJFS RESPONSIBILITIES

The following are ODJFS responsibilities or clarifications that are not otherwise specifically stated in OAC Chapter 5101:3-26 or elsewhere in the ODJFS-MCP provider agreement.

General Provisions

1. ODJFS will provide MCPs with an opportunity to review and comment on the rate-setting time line and proposed rates, and proposed changes to the OAC program rules or the provider agreement.

2. ODJFS will notify MCPs of managed care program policy and procedural changes and, whenever possible, offer sufficient time for comment and implementation.

3. ODJFS will provide regular opportunities for MCPs to receive program updates and discuss program issues with ODJFS staff.

4. ODJFS will provide technical assistance sessions where MCP attendance and participation is required. ODJFS will also provide optional technical assistance sessions to MCPs, individually or as a group.

5. ODJFS will provide MCPs with an annual MCP Calendar of Submissions outlining major submissions and due dates.

6. ODJFS will identify contact staff, including the Contract Administrator, selected for each MCP.

7. ODJFS will recalculate the minimum provider panel specifications if ODJFS determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population.

8. ODJFS will recalculate the geographic accessibility standards, using the geographic information systems (GIS) software, if ODJFS determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population and/or the ODJFS provider panel specifications.

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

10. On a monthly basis, ODJFS will provide MCPs with an electronic Provider Master File containing all the Ohio Medicaid FFS providers, which includes their Medicaid Provider

Number, as well as all providers who have been assigned a provider reporting number for current encounter data purposes. This file also includes NPI information when available.

11. ODJFS utilizes electronic commerce known as Transport Layer Security (TLS) for many processes and procedures that were previously limited by HIPAA privacy concerns to FAX, telephone, or hard copy. The use of TLS means that private health information (PHI) and the identification of consumers as Medicaid recipients can be shared between ODJFS and the contracting MCPs via e-mail such as reports, copies of letters, forms, hospital claims, discharge records, general discussions of member-specific information, etc.

12. ODJFS will immediately report to CMS any breach in privacy or security that compromises PHI, when reported by the MCP or ODJFS staff.

13. Service Area Designation

Membership in a service area is mandatory unless ODJFS approves membership in the service area for consumer initiated selections only. It is ODJFS' current intention to implement a mandatory managed care program in service areas wherever choice and capacity allow and the criteria in 42 CFR 438.50(a) are met.

14. Consumer Information

a. ODJFS, or its delegated entity, will provide membership notices, informational materials, and instructional materials relating to members and eligible individuals in a manner and format that may be easily understood. At least annually, ODJFS or designee will provide current MCP members with an open enrollment notice which describes the managed care program and includes information on the MCP options in the service area and other information regarding the managed care program as specified in 42 CFR 438.10.

b. ODJFS will notify members or ask MCPs to notify members about significant changes affecting contractual requirements, member services or access to providers.

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

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

15. Membership Selection and Premium Payment

a. The Managed Care Enrollment Center (MCEC) - The ODJFS-contracted MCEC will provide unbiased education, selection services, and community outreach for the Medicaid

managed care program. The MCEC shall operate a statewide toll-free telephone center to assist eligible individuals in selecting an MCP or choosing a health care delivery option.

The MCEC shall distribute the most current generic consumer guide that provides basic information about the managed care program, as well as ODJFS prior-approved MCP materials, such as solicitation brochures and provider directories, to consumers who request additional materials.

b. Auto-Assignment and New MCPs – When an MCP first enters a region or begins serving a new population within a region, ODJFS for a one year period, has the sole discretion to assign consumers by whatever method and standards it chooses for the region and population, irrespective of the methods and limitations outlined in this Appendix.

c. Auto-Assignment Limitations – In order to ensure market and program stability, ODJFS may limit an MCP's auto-assignments for a population (e.g., ABD or CFC) if they meet any of the following enrollment thresholds:

- 55% of the statewide ABD or CFC eligible population; and/or
- 70% of the ABD or CFC eligibles in any region with two MCPs; and/or
- 55% of the ABD or CFC eligibles in any region with three MCPs

Once an MCP meets one of these enrollment thresholds, the MCP will only be permitted to receive the additional new membership (in the region or statewide, as applicable) through: (1) consumer-initiated enrollment; and (2) auto-assignments which are based on previous enrollment in that MCP or based on an historical provider relationship with a provider who is not on the panel of any other MCP in that region. In the event that an MCP in a region meets one or more of these enrollment thresholds, ODJFS, in their sole discretion, may not impose the auto-assignment limitation and auto-assign members to the MCPs in that region as ODJFS deems appropriate.

d. Performance Based Auto-Assignments – Consumers who do not voluntarily select an MCP or are not auto-assigned to an MCP based on previous enrollment in that MCP or an historical provider relationship with a provider who is not on the panel of another MCP in that region, will be auto-assigned based on the MCP performance using the following performance rating system:

MCPs will be scored based on the following measures:

One Point

i. MCP Consumer Call Center (see Appendix C)
   - Average speed of answer
   - Abandonment rate
   - Blockage rate

ii. MCP Provider Call Center (measurement and standards will match those set for the MCP Consumer Call Center outlined in Appendix C).
- Average speed of answer
- Abandonment rate
- Blockage rate

iii. Prompt Payment of Claims (see Appendix J)
- Percentage of claims paid within 30days
- Percentage of claims paid within 90 days

Two Points

i. MCP Prior Authorization (see OAC 5101:3-26-03.1)
- Average time to process non-pharmacy requests

Each MCP will receive a specified number of points for meeting the established standard. If an MCP meets the established standard for each measure, they will receive ten points. Because these are performance based calculations, point calculations will be based solely on information reported by the MCP and will not be impacted by MCP requests for reconsideration under the Compliance Assessment System. For each region, the MCP with the highest score will receive the performance-based auto-assignments for the region. If there is a tie for the highest score, then each tying MCP will be considered equal in the auto-assignment process. Scoring will take place quarterly and will be based on the data that is available at the time the calculations are done. Scoring results will be applied to the auto-assignment process once the results are finalized.

On a regional basis, MCPs that have auto-assignment limitations in accordance with 15.b. do not qualify for performance-based auto-assignments unless (1) there are two MCPs in the region, (2) the auto-assignment limited MCP received 10 points and (3) the other MCP in the regional failed to receive 10 points. In this case, the MCP with the auto-assignment limitation shall receive auto-assignments in the amount of 10% of the performance based auto-assignments for every point the other MCP is below 10 points (i.e. if the other MCP has 7 points then the MCP would receive 30% [3 points * 10%]).

If ODJFS implements a new enrollment freeze on an MCP as outlined in Appendix N, the MCP will not receive any auto-assignments. Should ODJFS remove the new enrollment freeze, the MCP will not be entitled to receive performance based auto-assignments until the next quarterly review is performed and implemented as outlined in this section.

e. Consumer Contact Record (CCR): ODJFS or their designated entity shall forward CCRs to MCPs on no less than a weekly basis. The CCRs are a record of each consumer initiated MCP enrollment, change, or termination, and each MCEC initiated MCP assignment processed through the MCEC. The CCR contains information that is not included on the monthly member roster.

f. Member Roster (MR) - ODJFS verifies MCP enrollment via a membership roster. ODJFS or its designated entity provides a full member roster (F) and a change roster (C) via HIPAA 834 compliant transactions.

g. Monthly Premiums - ODJFS will remit payment to the MCPs via an electronic funds transfer (EFT), or at the discretion of ODJFS, by paper warrant.

h. Remittance Advice (RA) - ODJFS will confirm all premium payments paid to the MCP during the month via a monthly RA. ODJFS or its designated entity provides a record of each payment via HIPAA 820 compliant transactions.

i. MCP Membership/Payment Reconciliation - ODJFS will work with an MCP designated contact(s) in Appendix C to resolve the MCP's member and newborn eligibility inquiries, and premium and delivery inquiries/discrepancies and to review/approve hospital deferment requests.

16. ODJFS will make available a website which includes current program information.

17. ODJFS, or its contracted entity, will regularly provide information to MCPs regarding different aspects of MCP performance including, but not limited to, information on MCP-specific and statewide external quality review organization surveys, focused clinical quality of care studies, consumer satisfaction surveys and provider profiles.

18. ODJFS will periodically review a random sample of online and printed directories to assess whether MCP information is both accessible and updated.

19. Communications

a. ODJFS/BPHPS: The Bureau of Policy and Health Plan Services (BPHPS) is responsible for the oversight of the MCPs' provider agreements with ODJFS. Within the BPHPS, a specific Contract Administrator (CA) has been assigned to each MCP. Unless expressly directed otherwise, MCPs shall first contact their designated CA for questions/assistance related to Medicaid and/or the MCP's program requirements /responsibilities. If their CA is not available and the MCP needs immediate assistance, MCP staff should request to speak to a supervisor within the Contract Administration Section. MCPs should take all necessary and appropriate steps to ensure all MCP staff are aware of, and follow, this communication process.

b. ODJFS Contracting Entities: ODJFS-contracting entities should never be contacted by the MCPs unless the MCPs have been specifically instructed by ODJFS to contact the ODJFS contracting entity directly.

c. MCP Delegated Entities: In that MCPs are ultimately responsible for meeting program requirements, the BPHPS will not discuss MCP issues with the MCPs' delegated entities unless the applicable MCP is also participating in the discussion. MCP delegated

entities, with the applicable MCP participating, should only communicate with the specific CA assigned to that MCP.

# APPENDIX E

## RATE METHODOLOGY
## CFC ELIGIBLE POPULATION

Milliman

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111 Monument Circle
Suite 601
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milliman.com

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December 14, 2009

Mr. Jon Barley, Ph. D., Bureau Chief
Bureau of Managed Care
Ohio Department of Job and Family Services
Lazarus Building
50 West Town St., Suite 400
Columbus, OH 43215

**RE: CY 2010 CAPITATION RATE DEVELOPMENT – CFC – PROVIDER AGREEMENT**

Dear Jon:

Milliman, Inc. (Milliman) was retained by the State of Ohio, Department of Job and Family Services (ODJFS) to develop the calendar year (CY) 2010 actuarially sound capitation rates for the Covered Families and Children (CFC) Risk Based Managed Care (RBMC) program. This letter provides the documentation and certification for the actuarially sound capitation rates.

## LIMITATIONS

The information contained in this letter, including the enclosures, has been prepared for the State of Ohio, Department of Job and Family Services and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety including all supporting documentation. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data 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 ODJFS 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.

The information contained in this letter was prepared as documentation of the CFC capitation rates for Medicaid managed care organization health plans in the State of Ohio. The information may not be appropriate for any other purpose.



Offices in Principal Cities Worldwide

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## SUMMARY OF METHODOLOGY

ODJFS contracted with Milliman to develop the CY 2010 CFC actuarially sound capitation rates. The actuarially sound capitation rates were developed from historical claims and enrollment data for the managed care populations. The historical experience was converted to a per member per month (PMPM) basis and stratified by region, age and gender, and category of service. A separate capitation rate has been developed for the delivery payment. The historical experience was trended forward using projected trend rates to a center point of July 1, 2010 for the 2010 calendar year contract period. The historical experience was adjusted to reflect adjustments to the utilization and average cost per service that would be expected in a managed care environment.

Enclosure 1 contains a chart outlining the methodology that was used to develop the CY 2010 capitation rates for the CFC populations.

Enclosure 2 contains the actuarial certification regarding the actuarial soundness of the capitation rates.

Enclosure 3 contains the CY 2010 capitation rates by region, including the segmentation of the administrative cost allowance between guaranteed and at-risk components.

## DETAILS OF METHODOLOGY

### I. COVERED POPULATION

The CFC capitation rates have been developed to illustrate historical experience for the population eligible for managed care enrollment based on age, gender, and program assignment.

Milliman extracted the eligible population information from historical data. The eligible population includes the Healthy Start and Healthy Families population. If a member was ineligible during a month, all claims and eligibility for the month were excluded from the actuarial models.

### II. RATE GROUPS

The CFC capitation rates are segmented by region and rate group. The non-delivery rate groups vary by age, gender, and program assignment. The delivery rate group is determined based on the CFC Program Delivery Payment Reporting Procedures for ODJFS Managed Care Plans, as updated in August 2009.



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## III. DEVELOPMENT OF CY 2008 ADJUSTED ENCOUNTER DATA

### a. Historical Data Summaries

As discussed in other sections of this document, several adjustments were applied to the base encounter data to develop the 2010 calendar year capitation rates. This outlines each of the adjustments applied to the base encounter data.

Milliman incorporated encounter data for two calendar year periods for the experience incurred during the 12 months ending December 31, 2007 and December 31, 2008. The encounter data was developed from claims submitted through June, 2009.

The claims data was provided by ODJFS from the data warehouse. The experience was stratified into geographic region based on the member's county of residence.

The encounter data represents historical experience for those services that are included in the capitation payment. Services that are not covered under the capitation payment have been excluded from the experience.

### b. Cost per Service

The encounter claim experience contains cost information representing the source of the cost per service values in the actuarial model summaries.

The base cost per service amounts were reviewed for reasonableness and adjusted for sub-capitation claims that did not include a financial amount. The adjustment removed the utilization and cost information for these claims and calculated the cost per service amounts by region, rate group, and category of service for the remaining services. The utilization from all claims, including the claims with invalid cost information, was then applied to the revised cost per service amounts to generate a revised PMPM claim cost amount.

### c. Completion Factors

Milliman utilized 24 months of claims experience for the managed care population that was incurred through December 2008 and submitted to ODJFS through June 30, 2009. Milliman applied claim completion factors to the twelve months of calendar year 2007 and 2008 claims experience.

Milliman additionally included amounts in the *Non-Emergent Transportation* service category that were missing from the encounter base data. This would generally be adjusted as a percentage amount; however, the base encounter data was null for many rate groups and regions which required an explicit addition of PMPM values as opposed to percentage adjustments. Milliman included PMPM values that varied by region based on a review of the health plan submitted cost report and supplemental survey data.



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### d. Historical Program Adjustments

The base experience data represents a historical time period from which projections were developed. Certain program changes have occurred during and subsequent to the base data time period. The program adjustments were estimated and applied to the portion of the base experience data prior to the program change effective date. For example, a program change implemented on July 1, 2008 will only be reflected in the second half of CY 2008. As such, an adjustment was applied to all of CY 2007 and half of CY 2008 to include the program change in all periods of the base experience data.

### e. Third-Party Liability and Fraud-Abuse Recoveries

The cost reports and supplemental survey data submitted by the health plans contained information related to third-party liability and fraud-abuse recoveries. Milliman reviewed the reported recoveries and applied the average reduction among plans to all of the base encounter data.

### f. Non-State Plan Services

CMS requires removal of non-state plan services from rate-setting. The encounter data contains certain claims that are considered non-state plan services. The health plan submitted cost reports and supplemental survey data were used as the source of information for the non-state plan service adjustments.

Additionally, Milliman created adjustments to the encounter experience to reflect the reduction in the cost per service for State Plan co-payments that are not reflected in the base experience. These values were calculated from historical FFS experience for each affected category of service and rate group.

### g. Children in Care Adjustments

Milliman developed an adjustment to the base encounter experience to reflect the addition of voluntary Children in Care (CIC) enrollees into the base experience data. The historical data summaries do not include the CIC program assignment and, as such, do not include the claim experience for this subset of the managed care enrolled population. Milliman estimated the morbidity differences observed from the CIC population as compared to the CFC population and applied an adjustment factor to reflect the additional cost of these individuals into the base experience data.

### h. Historical Selection Adjustments

Milliman applied a historical selection adjustment to the base encounter data to reflect that the base period contains a combination of FFS and managed care enrollment. The historical selection adjustment is intended to normalize the encounter experience to the morbidity level of the entire managed care eligible population.



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### i. Medical Inflation to CY 2008

Milliman developed medical inflation rates to progress the historical CY 2007 experience forward to a common center point (CY 2008).

Milliman developed the medical inflation assumptions following a review of historical experience and internal data sources. The medical inflation rates are not intended to include artificial program adjustments, such as fee schedule changes or benefit modifications. The program adjustments are included in other adjustments in the capitation rate development process.

### j. Blend Base Experience Years

The base CY 2007 experience year was trended to CY 2008. At this point, each base year was on a comparable basis and could be aggregated. The weighting was developed with the intention of placing primary credibility on the most recent experience.

### k. Managed Care Adjustments

Utilization and cost per service adjustments were developed for each rate group, service category, and region.

***Utilization***

Milliman calculated percentage adjustments to the encounter base experience data to reflect the utilization differential between the base experience and the levels targeted for the managed care environment. The sources of information included:

- State of Ohio specific policies and provider environment;
- Historical managed care experience by health plan, region, and rate cell;
- NYU Emergency Department Algorithm (ED Only); and.
- Internal research and actuarial judgment.

The managed care utilization adjustments were developed in an iterative process and did not follow a prescribed formula. The general steps followed are outlined below:

- Review the resulting adjustments for reasonableness and identify categories of services outside of the expected range; and,
- Develop specific adjustments for emergency department service categories reviewing health plan specific experience as well as other sources of information.

**ED Adjustments:** Specifically for the emergency department (ED) service category, Milliman reviewed the resulting classification of claims using the NYU Center for Health and Public Service Research



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(CHPSR) ED Algorithm. The tool classifies ED utilization into four (4) primary categories as well as categories that are excluded from the grouping. The four categories include: Non-emergent, Emergent/Primary Care Treatable, Emergent–Preventable/Avoidable, and Emergent–Not Preventable/Avoidable. Subsequent to the review of the experience into these defined categories, Milliman developed specific adjustments for the first three categories to reflect the target utilization levels for the managed care plans. The following illustrates the adjustments by ED classification:

- Non-emergent – 50% Reduction
- Emergent/Primary Care Treatable – 33% Reduction
- Emergent – Preventable/Avoidable – 10% Reduction

Further, 75% of the ED visits reduced were replaced with an office visit and the reductions were also offset by an increase of 5% in ED visits assumed due to the pharmacy carve-out initiative.

***Cost Per Service – Mix/Intensity***

Milliman adjusted the cost per service amounts to reflect changes in the mix / intensity of services due to the incremental changes in utilization described above. The cost per service changes were developed following a review of historical managed care encounter data as well as internal sources of information.

***Cost Per Service – Provider Contracting Adjustments***

In addition to the intensity adjustments applied to the cost per service amounts, Milliman also included adjustments to reflect the health plan contracted rates with providers in the managed care adjustments. Milliman reviewed the information provided by the health plans in the reimbursement survey responses as well as the cost information contained on the encounter data. From this review, Milliman developed target percentages of the FFS Medicaid reimbursement rates.

## IV. DEVELOPMENT OF CY 2008 ADJUSTED COST REPORT DATA

### a. Historical Data Summaries

As discussed in other sections of this document, several adjustments were applied to the base cost report data to develop the calendar year 2010 capitation rates. This section outlines each of the adjustments applied to the base cost report data.

Milliman incorporated cost report data for two calendar year periods for the experience incurred during the 12 months ending December 31, 2007 and December 31, 2008. The cost report data was developed with claims paid through December 31, 2008.

The historical data summaries for the base cost report experience reflect only region and health plan combinations with sufficient experience to be considered credible.



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**b. Completion Factors**

The cost reports contained claim experience incurred through December 31, 2008 and paid through December 31, 2008. Milliman reviewed the June 30, 2009 quarterly statutory reserve restatements contained on page 9 of the respective Underwriting and Investment exhibits to determine the amount of understatement or overstatement of reserves as of December 31, 2008.

**c. Historical Program Adjustments**

The base experience data represents a historical time period from which projections were developed. Certain program changes have occurred during and subsequent to the base data time period. The program adjustments were estimated and applied to the portion of the base experience data prior to the program change effective date. For example, a program change implemented on July 1, 2008 will only be reflected in the second half of CY 2008. As such, an adjustment was applied to all of CY 2007 and half of CY 2008 to include the program change in all periods of the base experience data.

**d. Third-Party Liability and Fraud-Abuse Recoveries**

The cost reports and supplemental survey data submitted by the health plans contained information related to third-party liability and fraud-abuse recoveries. Milliman reviewed the reported recoveries and applied the average reduction to all of the base cost report data.

**e. Non-State Plan Services**

CMS requires removal of non-state plan services from rate-setting. The cost report data contains certain claims that are considered non-state plan services. The health plan submitted cost reports and supplemental survey data were used as the source of information for the non-state plan service adjustments.

Additionally, Milliman created adjustments to the cost report experience to reflect the reduction in the cost per service for State Plan co-payments that are not reflected in the base experience. These values were calculated from historical FFS experience for each affected category of service and rate group.

**f. Historical Selection Adjustments**

Milliman applied a historical selection adjustment to the base cost report data to reflect that the base period contains a combination of FFS and managed care enrollment. The historical selection adjustment is intended to normalize the cost report experience to the morbidity level of the entire managed care eligible population.



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### g. Medical Inflation to CY 2008

Milliman developed medical inflation rates to progress the historical CY 2007 experience forward to a common center point (CY 2008). The composite trend was developed from the encounter data annual trends. This methodology was selected since the cost reports are included in total by region and allocated to service categories and rate groups using the proportion observed in the encounter data.

### h. Blend Base Experience Years

The base CY 2007 year was trended to CY 2008. At this point, each base year was on a comparable basis and could be aggregated. The weighting was developed with the intention of placing primary credibility on the most recent experience.

### i. Managed Care Adjustments

Milliman adjusted the cost report experience data to reflect changes anticipated in the managed care environment. The cost report base experience was adjusted using the same managed care adjustments as the base encounter data.

Utilization and cost per service adjustments were developed for each rate group, service category, and region.

## V. CY 2008 ADJUSTED BASE DATA TO CY 2010 CAPITATION RATES

The adjusted CY 2008 utilization and cost per service rates are trended forward to CY 2010 and adjusted for prospective program changes that will be effective for the CY 2010 contract period. The resulting PMPM establishes the regional adjusted claim cost for the health plans in CY 2010. The non-claim items (administrative cost allowance, sales and use taxes, and the HIC tax) are applied to the adjusted claim cost to develop the CY 2010 capitation rates.

### a. Medical Inflation Adjustments to CY 2010

The medical inflation rates that were used to progress the CY 2008 experience forward to the CY 2010 rating period were developed from the historical experience, the experience from other Medicaid managed care programs, and our actuarial judgment.

### b. Prospective Program Adjustments

The State Fiscal Year 2010/2011 Budget contains several program changes that impacted the development of the capitation rates. The program changes include items such as provider fee changes,



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benefit changes, and administrative changes. Adjustments to the CY 2008 experience were developed for each item based on its expected impact to the prospective claims cost.

### c. Prospective Selection Adjustment

Milliman adjusted the CY 2008 experience to reflect the expected penetration of managed care in CY 2010.

### d. Clinical Measures Adjustments

Appendix M of the provider agreement between the contracted health plans and ODJFS contains certain clinical measures that each health plan must achieve. The agreement stipulates that, at a minimum, the experience improvement must reduce the discrepancy between the ultimate target and the actual rate by a certain percentage. Milliman developed adjustments to the capitation rates to reflect this required improvement in performance based on the CY 2007 actual results.

### e. Blend Encounter / Cost Report

The encounter and cost report data sets were projected to CY 2010 and composited to establish the CY 2010 total claims cost. The weights between the encounter and cost report data sources reflect the intention to place more reliance upon health plan submitted encounter data.

### f. Age/Gender Realignment

Milliman developed the 2010 capitation rates by rate group and region. The resulting capitation rates by rate group were then adjusted within each region to realign the age/gender relativities among regions. The realignment maintains the composite capitation rates for each region and in aggregate while allowing for more consistent age/gender relativities.

### g. Administrative Allowance

Milliman included an administrative cost allowance in the development of the actuarially sound capitation rates for CY 2010. The administrative cost allowance contains provision for administrative expenses, profit/contingency, and capital/surplus contribution.

Milliman developed the administrative cost allowance separately for the administration expense, profit/contingency, and capital/surplus contribution components. The administration PMPM was calculated by trending the CY 2009 administration PMPM and re-allocating certain pharmacy administration amounts to the medical categories to reflect the removal of pharmacy from the capitation rate covered services.



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The reallocation of pharmacy administration reflects that the administrative component for the medical categories differs from that of the pharmacy category despite the historical methodology of using a uniform percentage across all service categories.

The trend rate assumed for the administration PMPM was developed following a review of the current Employment Cost Index and the CPI-U Index published by the Bureau of Labor Statistics as well as the historical administrative trends for Medicaid health plans in other states.

The profit/contingency and capital/surplus contribution components are a direct percentage of the pre-tax capitation rate due to the nature of these items.

For health plans in plan year 3 or later, 1% of the pre-tax capitation rate will be at-risk and contingent upon performance requirements defined in the ODJFS provider agreements. Additionally, all plans will be eligible for a pharmacy incentive bonus of 0.25% included in the Non-Delivery capitation rates. The specific requirements for the Pharmacy Incentive Bonus will be included in the provider agreements.

**h. Sales and Use Tax and HIC Tax**

Milliman included a Sales and Use tax and Health Insuring Corporation (HIC) tax component in the development of the actuarially sound capitation rates for CY 2010. The taxes were calculated as a percentage of the capitation rates.

If you have any questions regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures



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# ENCLOSURE 1



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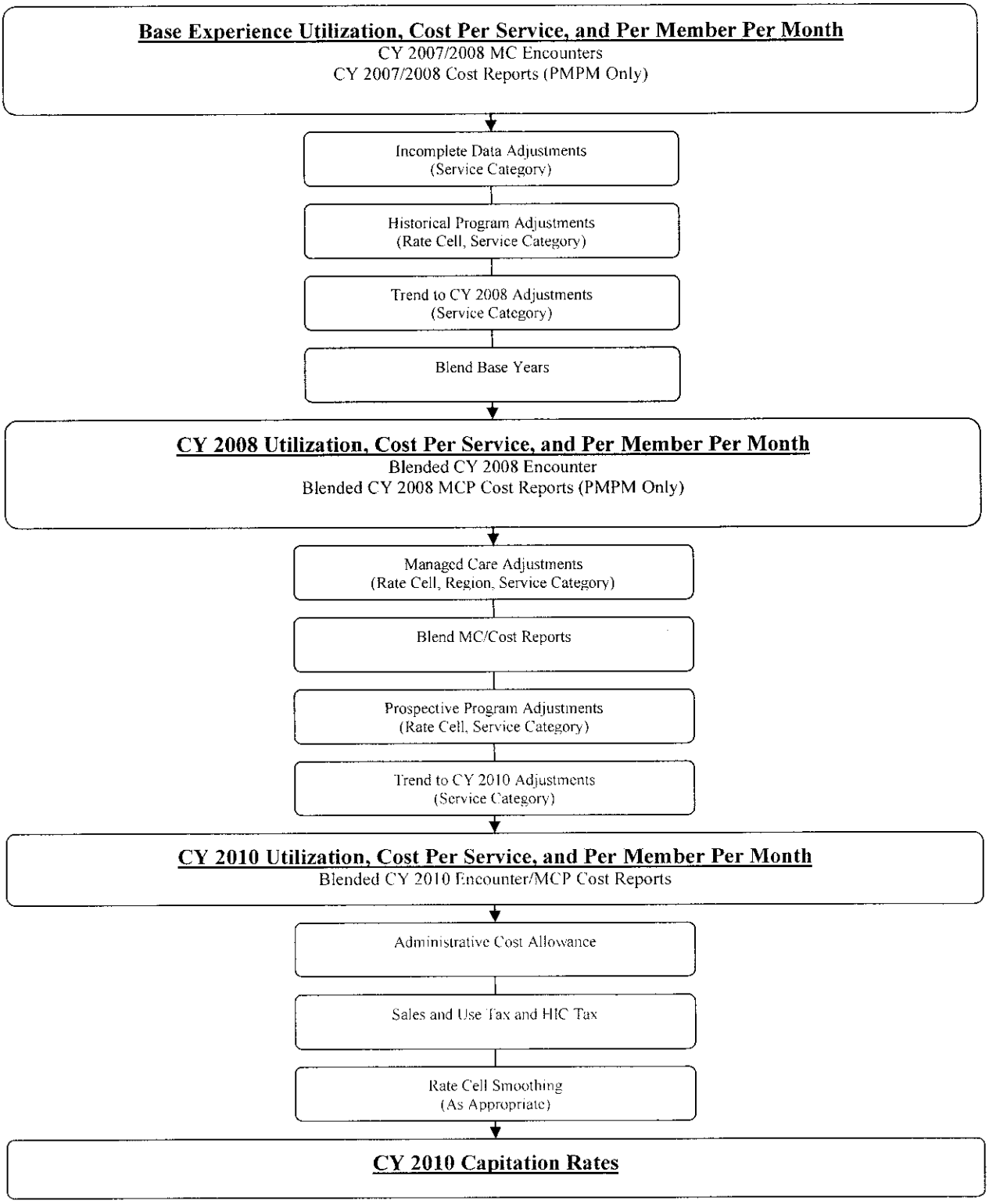




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# ENCLOSURE 2



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**STATE OF OHIO**
**DEPARTMENT OF JOB AND FAMILY SERVICES**
**Covered Families and Children – CY 2010 Capitation Rates**

**Actuarial Certification**

I, Robert M. Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I was retained by the State of Ohio, Department of Job and Family Services to perform an actuarial review and certification regarding the development of the capitation rates to be effective for calendar year 2010. The capitation rates were developed for the Covered Families and Children managed care eligible populations. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion.

I reviewed the historical claims experience for reasonableness and consistency. I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods. I have complied with the elements of the rate setting checklist CMS developed for its Regional Offices regarding 42 CFR 438.6(c) for capitated Medicaid managed care plans.

The capitation rates provided with this certification are effective for a one-year rating period beginning January 1, 2010 through December 31, 2010. At the end of the one-year period, the capitation rates will be updated for calendar year 2011. The update may be based on managed care utilization and trend experience, policy and procedure changes, and other changes in the health care market. A separate certification will be provided with the updated rates.

The capitation rates provided with this certification are considered actuarially sound, defined as:

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

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Robert M. Damler

Robert M. Damler, FSA
Member, American Academy of Actuaries

December 9, 2009
Date



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# ENCLOSURE 3



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# State of Ohio
## Department of Job and Family Services
## Capitation Rate Summary - Rate Group Level

| Region | Rate Group | Projected CY 2010 MMs/Deliveries | % of MMs | CY 2010 Guaranteed Rate | CY 2010 At Risk Rate | CY 2010 Rx Incentive Bonus | CY 2010 Rate |
|---|---|---|---|---|---|---|---|
| Central | HF/HST <1 M+F | 183,090 | 5.7% | $ 595.36 | $ 5.55 | $ 1.39 | $ 602.30 |
| Central | HF/HST 1 M+F | 169,461 | 5.3% | 140.41 | 1.31 | 0.33 | 142.05 |
| Central | HF/HST 2-13 M+F | 1,524,928 | 47.5% | 86.77 | 0.81 | 0.20 | 87.78 |
| Central | HF/HST 14-18 M | 216,560 | 6.7% | 105.78 | 0.99 | 0.25 | 107.02 |
| Central | HF/HST 14-18 F | 226,932 | 7.1% | 158.73 | 1.48 | 0.37 | 160.58 |
| Central | HF 19-44 M | 186,641 | 5.8% | 221.69 | 2.07 | 0.52 | 224.28 |
| Central | HF 19-44 F | 593,162 | 18.5% | 317.21 | 2.96 | 0.74 | 320.91 |
| Central | HF 45+ M+F | 67,709 | 2.1% | 467.65 | 4.36 | 1.09 | 473.10 |
| Central | HST 19-64 F | 40,633 | 1.3% | 445.87 | 4.16 | 1.04 | 451.07 |
| Central | Composite Non-Delivery | 3,209,116 | | 188.02 | 1.75 | 0.44 | 190.21 |
| Central | Delivery CFC | 11,548 | | 4,193.24 | 39.03 | - | 4,232.27 |
| Central | Composite with Delivery | 3,209,116 | | $ 203.11 | $ 1.89 | $ 0.44 | $ 205.44 |
| East Central | HF/HST <1 M+F | 100,544 | 5.6% | $ 567.02 | $ 5.30 | $ 1.33 | $ 573.65 |
| East Central | HF/HST 1 M+F | 86,414 | 4.8% | 133.74 | 1.25 | 0.31 | 135.30 |
| East Central | HF/HST 2-13 M+F | 824,889 | 46.2% | 82.65 | 0.77 | 0.19 | 83.61 |
| East Central | HF/HST 14-18 M | 126,107 | 7.1% | 100.76 | 0.94 | 0.24 | 101.94 |
| East Central | HF/HST 14-18 F | 135,076 | 7.6% | 151.19 | 1.41 | 0.35 | 152.95 |
| East Central | HF 19-44 M | 102,594 | 5.8% | 211.16 | 1.98 | 0.49 | 213.63 |
| East Central | HF 19-44 F | 343,546 | 19.3% | 302.12 | 2.83 | 0.71 | 305.66 |
| East Central | HF 45+ M+F | 41,938 | 2.4% | 445.43 | 4.17 | 1.04 | 450.64 |
| East Central | HST 19-64 F | 22,940 | 1.3% | 424.71 | 3.97 | 0.99 | 429.67 |
| East Central | Composite Non-Delivery | 1,784,048 | | 181.47 | 1.70 | 0.42 | 183.59 |
| East Central | Delivery CFC | 6,905 | | 4,724.25 | 44.09 | - | 4,768.34 |
| East Central | Composite with Delivery | 1,784,048 | | $ 199.76 | $ 1.87 | $ 0.42 | $ 202.05 |
| Northeast | HF/HST <1 M+F | 159,699 | 5.3% | $ 559.27 | $ 5.19 | $ 1.30 | $ 565.76 |
| Northeast | HF/HST 1 M+F | 143,288 | 4.7% | 131.89 | 1.22 | 0.31 | 133.42 |
| Northeast | HF/HST 2-13 M+F | 1,413,585 | 46.5% | 81.50 | 0.76 | 0.19 | 82.45 |
| Northeast | HF/HST 14-18 M | 233,509 | 7.7% | 99.38 | 0.92 | 0.23 | 100.53 |
| Northeast | HF/HST 14-18 F | 248,420 | 8.2% | 149.10 | 1.38 | 0.35 | 150.83 |
| Northeast | HF 19-44 M | 137,162 | 4.5% | 208.27 | 1.93 | 0.48 | 210.68 |
| Northeast | HF 19-44 F | 585,707 | 19.3% | 297.97 | 2.76 | 0.69 | 301.42 |
| Northeast | HF 45+ M+F | 81,033 | 2.7% | 439.32 | 4.07 | 1.02 | 444.41 |
| Northeast | HST 19-64 F | 34,934 | 1.2% | 418.85 | 3.88 | 0.97 | 423.70 |
| Northeast | Composite Non-Delivery | 3,037,337 | | 176.80 | 1.64 | 0.41 | 178.85 |
| Northeast | Delivery CFC | 10,336 | | 4,709.87 | 43.57 | - | 4,753.44 |
| Northeast | Composite with Delivery | 3,037,337 | | $ 192.83 | $ 1.79 | $ 0.41 | $ 195.03 |
| Northeast Central | HF/HST <1 M+F | 42,280 | 5.0% | $ 601.81 | $ 5.62 | $ 1.40 | $ 608.83 |
| Northeast Central | HF/HST 1 M+F | 38,424 | 4.6% | 141.94 | 1.33 | 0.33 | 143.60 |
| Northeast Central | HF/HST 2-13 M+F | 382,446 | 45.7% | 87.71 | 0.82 | 0.20 | 88.73 |
| Northeast Central | HF/HST 14-18 M | 65,756 | 7.9% | 106.94 | 1.00 | 0.25 | 108.19 |
| Northeast Central | HF/HST 14-18 F | 68,758 | 8.2% | 160.47 | 1.50 | 0.37 | 162.34 |
| Northeast Central | HF 19-44 M | 46,770 | 5.6% | 224.11 | 2.09 | 0.52 | 226.72 |
| Northeast Central | HF 19-44 F | 160,920 | 19.2% | 320.63 | 2.99 | 0.75 | 324.37 |
| Northeast Central | HF 45+ M+F | 21,268 | 2.5% | 472.77 | 4.41 | 1.10 | 478.28 |
| Northeast Central | HST 19-64 F | 10,982 | 1.3% | 450.74 | 4.21 | 1.05 | 456.00 |
| Northeast Central | Composite Non-Delivery | 837,604 | | 190.53 | 1.78 | 0.44 | 192.75 |
| Northeast Central | Delivery CFC | 2,695 | | 4,468.99 | 41.63 | - | 4,510.62 |
| Northeast Central | Composite with Delivery | 837,604 | | $ 204.91 | $ 1.91 | $ 0.44 | $ 207.26 |
| Northwest | HF/HST <1 M+F | 104,193 | 6.2% | $ 576.35 | $ 5.38 | $ 1.34 | $ 583.07 |
| Northwest | HF/HST 1 M+F | 86,475 | 5.2% | 135.91 | 1.27 | 0.32 | 137.50 |
| Northwest | HF/HST 2-13 M+F | 774,300 | 46.4% | 84.00 | 0.78 | 0.20 | 84.98 |
| Northwest | HF/HST 14-18 M | 112,197 | 6.7% | 102.40 | 0.96 | 0.24 | 103.60 |
| Northwest | HF/HST 14-18 F | 118,408 | 7.1% | 153.67 | 1.43 | 0.36 | 155.46 |
| Northwest | HF 19-44 M | 99,373 | 5.9% | 214.62 | 2.00 | 0.50 | 217.12 |
| Northwest | HF 19-44 F | 318,410 | 19.1% | 307.04 | 2.87 | 0.72 | 310.63 |
| Northwest | HF 45+ M+F | 34,019 | 2.0% | 452.68 | 4.22 | 1.06 | 457.96 |
| Northwest | HST 19-64 F | 23,172 | 1.4% | 431.62 | 4.03 | 1.01 | 436.66 |
| Northwest | Composite Non-Delivery | 1,670,547 | | 186.17 | 1.74 | 0.44 | 188.35 |
| Northwest | Delivery CFC | 6,816 | | 4,364.64 | 40.64 | - | 4,405.28 |
| Northwest | Composite with Delivery | 1,670,547 | | $ 203.97 | $ 1.91 | $ 0.44 | $ 206.32 |

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**State of Ohio**
**Department of Job and Family Services**
**Capitation Rate Summary - Rate Group Level**

| Region | Rate Group | Projected CY 2010 MMs/Deliveries | % of MMs | CY 2010 Guaranteed Rate | CY 2010 At Risk Rate | CY 2010 Rx Incentive Bonus | CY 2010 Rate |
|---|---|---|---|---|---|---|---|
| Southeast | HF/HST <1 M+F | 56,422 | 5.3% | $ 554.28 | $ 5.16 | $ 1.29 | $ 560.73 |
| Southeast | HF/HST 1 M+F | 46,904 | 4.4% | 130.71 | 1.22 | 0.30 | 132.23 |
| Southeast | HF/HST 2-13 M+F | 478,634 | 44.5% | 80.78 | 0.75 | 0.19 | 81.72 |
| Southeast | HF/HST 14-18 M | 82,229 | 7.7% | 98.49 | 0.92 | 0.23 | 99.64 |
| Southeast | HF/HST 14-18 F | 83,974 | 7.8% | 147.79 | 1.38 | 0.34 | 149.51 |
| Southeast | HF 19-44 M | 86,793 | 8.1% | 206.42 | 1.92 | 0.48 | 208.82 |
| Southeast | HF 19-44 F | 201,479 | 18.8% | 295.29 | 2.75 | 0.69 | 298.73 |
| Southeast | HF 45+ M+F | 26,185 | 2.4% | 435.39 | 4.05 | 1.01 | 440.45 |
| Southeast | HST 19-64 F | 11,775 | 1.1% | 415.14 | 3.87 | 0.97 | 419.98 |
| Southeast | Composite Non-Delivery | 1,074,395 | | 177.10 | 1.65 | 0.41 | 179.16 |
| Southeast | Delivery CFC | 3,629 | | 3,935.44 | 36.56 | - | 3,972.00 |
| Southeast | Composite with Delivery | 1,074,395 | | $ 190.40 | $ 1.77 | $ 0.41 | $ 192.58 |
| Southwest | HF/HST <1 M+F | 128,841 | 6.5% | $ 642.47 | $ 6.01 | $ 1.50 | $ 649.98 |
| Southwest | HF/HST 1 M+F | 109,500 | 5.5% | 151.52 | 1.42 | 0.35 | 153.29 |
| Southwest | HF/HST 2-13 M+F | 962,772 | 48.5% | 93.63 | 0.88 | 0.22 | 94.73 |
| Southwest | HF/HST 14-18 M | 129,829 | 6.5% | 114.16 | 1.07 | 0.27 | 115.50 |
| Southwest | HF/HST 14-18 F | 143,312 | 7.2% | 171.31 | 1.60 | 0.40 | 173.31 |
| Southwest | HF 19-44 M | 89,440 | 4.5% | 239.25 | 2.24 | 0.56 | 242.05 |
| Southwest | HF 19-44 F | 356,236 | 18.0% | 342.28 | 3.20 | 0.80 | 346.28 |
| Southwest | HF 45+ M+F | 38,095 | 1.9% | 504.65 | 4.72 | 1.18 | 510.55 |
| Southwest | HST 19-64 F | 26,320 | 1.3% | 481.18 | 4.50 | 1.13 | 486.81 |
| Southwest | Composite Non-Delivery | 1,984,345 | | 203.64 | 1.91 | 0.48 | 206.03 |
| Southwest | Delivery CFC | 8,178 | | 4,779.17 | 44.61 | - | 4,823.78 |
| Southwest | Composite with Delivery | 1,984,345 | | $ 223.34 | $ 2.09 | $ 0.48 | $ 225.91 |
| West Central | HF/HST <1 M+F | 87,354 | 6.1% | $ 585.10 | $ 5.45 | $ 1.36 | $ 591.91 |
| West Central | HF/HST 1 M+F | 74,505 | 5.2% | 137.98 | 1.28 | 0.32 | 139.58 |
| West Central | HF/HST 2-13 M+F | 672,365 | 47.1% | 85.27 | 0.79 | 0.20 | 86.26 |
| West Central | HF/HST 14-18 M | 95,468 | 6.7% | 103.97 | 0.97 | 0.24 | 105.18 |
| West Central | HF/HST 14-18 F | 104,241 | 7.3% | 156.01 | 1.45 | 0.36 | 157.82 |
| West Central | HF 19-44 M | 75,823 | 5.3% | 217.87 | 2.03 | 0.51 | 220.41 |
| West Central | HF 19-44 F | 269,285 | 18.9% | 311.72 | 2.90 | 0.73 | 315.35 |
| West Central | HF 45+ M+F | 30,139 | 2.1% | 459.57 | 4.28 | 1.07 | 464.92 |
| West Central | HST 19-64 F | 18,266 | 1.3% | 438.18 | 4.08 | 1.02 | 443.28 |
| West Central | Composite Non-Delivery | 1,427,446 | | 187.20 | 1.74 | 0.44 | 189.38 |
| West Central | Delivery CFC | 5,670 | | 5,010.64 | 46.55 | - | 5,057.19 |
| West Central | Composite with Delivery | 1,427,446 | | $ 207.11 | $ 1.92 | $ 0.44 | $ 209.47 |
| Statewide | HF/HST <1 M+F | 862,423 | 5.7% | $ 586.70 | $ 5.47 | $ 1.37 | $ 593.54 |
| Statewide | HF/HST 1 M+F | 754,971 | 5.0% | 138.36 | 1.29 | 0.32 | 139.97 |
| Statewide | HF/HST 2-13 M+F | 7,033,919 | 46.8% | 85.36 | 0.80 | 0.20 | 86.36 |
| Statewide | HF/HST 14-18 M | 1,061,655 | 7.1% | 103.79 | 0.97 | 0.24 | 105.00 |
| Statewide | HF/HST 14-18 F | 1,129,121 | 7.5% | 155.82 | 1.45 | 0.36 | 157.63 |
| Statewide | HF 19-44 M | 824,596 | 5.5% | 217.37 | 2.03 | 0.51 | 219.91 |
| Statewide | HF 19-44 F | 2,828,745 | 18.8% | 311.52 | 2.90 | 0.73 | 315.15 |
| Statewide | HF 45+ M+F | 340,386 | 2.3% | 457.93 | 4.27 | 1.07 | 463.27 |
| Statewide | HST 19-64 F | 189,022 | 1.3% | 439.11 | 4.09 | 1.02 | 444.22 |
| Statewide | Composite Non-Delivery | 15,024,838 | | 186.11 | 1.74 | 0.43 | 188.28 |
| Statewide | Delivery CFC | 55,777 | | 4,541.20 | 42.24 | - | 4,583.44 |
| Statewide | Composite with Delivery | 15,024,838 | | $ 202.97 | $ 1.90 | $ 0.43 | $ 205.30 |

# APPENDIX E

## RATE METHODOLOGY
## ABD ELIGIBLE POPULATION

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December 14, 2009

Mr. Jon Barley, Ph. D., Bureau Chief
Bureau of Managed Care
Ohio Department of Job and Family Services
Lazarus Building
50 West Town St., Suite 400
Columbus, OH 43215

**RE: CY 2010 CAPITATION RATE DEVELOPMENT –ABD – PROVIDER AGREEMENT**

Dear Jon:

Milliman, Inc. (Milliman) was retained by the State of Ohio, Department of Job and Family Services (ODJFS) to develop the calendar year (CY) 2010 actuarially sound capitation rates for the Aged, Blind, or Disabled (ABD) Risk Based Managed Care (RBMC) program. This letter provides the documentation and certification for the actuarially sound capitation rates.

## LIMITATIONS

The information contained in this letter, including the enclosures, has been prepared for the State of Ohio, Department of Job and Family Services and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed 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 data 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 ODJFS 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.

The information contained in this letter was prepared as documentation of the ABD capitation rates for Medicaid managed care organization health plans in the State of Ohio. The information may not be appropriate for any other purpose.



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## SUMMARY OF METHODOLOGY

ODJFS contracted with Milliman to develop the CY 2010 ABD actuarially sound capitation rates. The actuarially sound capitation rates were developed from historical claims and enrollment data for the fee for service (FFS) and managed care populations. The composite of the FFS and managed care populations are considered a comparable population to the population enrolled with the health plans. The historical experience was converted to a per member per month (PMPM) basis and stratified by region and category of service. The historical experience was trended forward using projected trend rates to a center point of July 1, 2010 for the 2010 calendar year contract period. The historical experience was adjusted to reflect adjustments to the utilization and average cost per service that would be expected in a managed care environment.

Enclosure 1 contains a chart outlining the methodology that was used to develop the CY 2010 capitation rates for the ABD populations.

Enclosure 2 contains the actuarial certification regarding the actuarial soundness of the capitation rates.

Enclosure 3 contains the CY 2010 capitation rates by region, including the segmentation of the administrative cost allowance between guaranteed and at-risk components.

## DETAILS OF METHODOLOGY

### I. COVERED POPULATION

The ABD capitation rates have been developed for the population eligible for managed care enrollment based on specific categories defined by the state.

Milliman extracted the eligible population information from historical data. The eligible population includes the adult ABD population excluding: retro-active periods, back-dated periods, institutionalized, waiver, spend-down, Medicare dual-eligibles, and long-term nursing facility recipients. Adults are defined based on age greater than or equal to 21 during the base experience period. Long-term nursing facility was defined as stays lasting past the last day of the month following the admission to the nursing facility.

If a member was ineligible during a month, all claims and eligibility for the month were excluded from the actuarial models.

### II. RATE GROUPS

The rate certification includes the documentation of the development of the CY 2010 capitation rates for each region. The ABD capitation rates will be risk adjusted using the Chronic Illness and Disability Payment System (CDPS). As such, the ABD capitation rates are provided in one single rate group.



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Further information regarding the CDPS risk adjustment is contained in a later section as well as documented in detail in other correspondence provided by Milliman.

## III. DEVELOPMENT OF CY 2008 ADJUSTED FFS DATA

### a. Historical Data Summaries

As discussed in other sections of this document, several adjustments were applied to the base FFS data to determine the 2010 calendar year capitation rates. The following outlines each of the adjustments applied to the base FFS data.

Milliman incorporated FFS claims for two calendar year periods for the experience incurred during the 12 months ending December 31, 2007 and December 31, 2008. The base data was developed from claims paid through March 31, 2009.

The claims data was provided by ODJFS from the data warehouse. The experience was stratified into geographic region based on the member's county of residence.

The reimbursement amounts captured on the FFS actuarial models reflect the amount paid by ODJFS as indicated in the claim processing system. The reimbursement amounts have not been adjusted for payments made outside the claims processing system. These amounts are discussed later in the documentation.

The FFS claims data represents historical experience for those services that are included in the capitation payment. Services that are not covered under the capitation payment have been excluded from the experience. The excluded services were identified by the ODJFS defined category of service field.

### b. Completion Factors

Milliman utilized 24 months of claims experience for the FFS population that was incurred through December 2008 and paid through March 2009 (three months of run-out). Milliman applied claim completion factors to the twelve months of calendar year 2007 and twelve months of calendar year 2008 claims experience. The claim completion factors were developed by service category based on restated claims experience for the FFS population incurred and paid through June 2009 to reduce the amount of uncertainty inherent in the CY 2008 base experience resulting from only 3 months of paid claim run-out.

### c. Historical Program Adjustments

The base experience data represents a historical time period from which projections were developed. Certain program changes have occurred during and subsequent to the base data time period. The program adjustments were estimated and applied to the portion of the base experience data prior to the program



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change effective date. For example, a program change implemented on July 1, 2008 will only be reflected in the second half of CY 2008. As such, an adjustment was applied to all of CY 2007 and half of CY 2008 to include the program change in all periods of the base experience data.

### d. Third-Party Liability

The FFS experience was calculated using the net paid claim data from the FFS data provided by ODJFS. The paid amounts reflect a reduction for the amounts paid by third party carriers. Additionally, Milliman reduced the FFS experience to reflect third party liability recoveries following payment of claims. The reduction represents the average third party liability recovery rate received by the state under the "pay-and-chase" recovery program for each base year. It is expected that the health plans will collect the third party liability recoveries for managed care enrolled individuals.

### e. Fraud and Abuse

The FFS experience was calculated using the net paid claim data from the FFS data provided by ODJFS. Milliman reduced the FFS experience to reflect fraud and abuse recoveries following payment of claims. The reduction represents the average fraud and abuse recovery rate received by the state for each base year. It is expected that the health plans will pursue fraud and abuse detection activities for managed care enrolled individuals.

### f. Gross Adjustments

The FFS experience was calculated using the net paid claim data from the FFS data provided by ODJFS. Milliman adjusted the FFS experience to reflect payments/refunds occurring outside of normal claim adjudication. Milliman received a "gross adjustments" file from ODJFS containing the additional adjustments.

### g. Non-State Plan Services

CMS requires removal of non-state plan services from rate-setting. The FFS data does not contain any such services. As such, no adjustment was applied to the base FFS data for non-state plan services.

### h. Historical Selection Adjustments

Milliman applied a historical selection adjustment to the base FFS data to reflect that the base period contains a combination of FFS and managed care enrollment. The historical selection adjustment is intended to normalize the FFS experience to the morbidity level of the entire managed care eligible population.



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Milliman developed a selection curve following a review of the CDPS risk scores for each region and the corresponding managed care penetration.

### i. Medical Inflation to CY 2008

Milliman developed medical inflation rates to progress the historical experience to a common center point (Midpoint of CY 2008). Due to the timing of the managed care migration, trend months vary to reflect that each region contained a member month midpoint that varied from the calendar midpoint due to the timing of the managed care migration.

Milliman developed the medical inflation assumptions following a review of historical experience and internal data sources. The medical inflation rates are not intended to include artificial program adjustments, such as fee schedule changes or benefit modifications. The program adjustments are included in other adjustments in the capitation rate development process.

### j. Blend Base Experience Years

The base experience was trended to the midpoint of CY 2008. At this point, each base year was on a comparable basis and could be aggregated. The weighting was developed with the intention of placing primary credibility on the CY 2008 experience.

### k. Managed Care Adjustments

Utilization and cost per service adjustments were developed for each service category and region.

*Utilization*

Milliman calculated percentage adjustments to the FFS base experience data to reflect the utilization differential between the FFS base experience and the managed care environment. The sources of information included:

- State of Ohio specific policies and provider environment;
- Historical managed care experience by health plan and region;
- Historical fee-for-service experience;
- NYU Emergency Department Algorithm (ED Only); and,
- Internal research and actuarial judgment.

The managed care utilization adjustments were developed in an iterative process and did not follow a prescribed formula. The general steps followed are outlined below:



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- Calculate the adjustments implied by the historical managed care experience by region and category of service;
- Review the resulting adjustments for reasonableness and identify categories of service outside of the expected range; and,
- Develop specific adjustments for service categories outside of the expected range by reviewing health plan specific experience as well as other sources of information.

**ED Adjustments:** Specifically for the emergency department (ED) service category, Milliman reviewed the resulting classification of claims using the NYU Center for Health and Public Service Research (CHPSR) ED Algorithm. The tool classifies ED utilization into four (4) primary categories as well as categories that are excluded from the grouping. The four categories include: Non-emergent, Emergent/Primary Care Treatable, Emergent–Preventable/Avoidable, and Emergent–Not Preventable/Avoidable. Subsequent to the review of the experience into these defined categories, Milliman developed specific adjustments for the first three categories to reflect the target utilization levels for the managed care plans. The following illustrates the adjustments by ED classification:

- Non-emergent – 50% Reduction
- Emergent/Primary Care Treatable – 33% Reduction
- Emergent – Preventable/Avoidable – 10% Reduction

Further, 75% of the ED visits reduced were replaced with an office visit and the reductions were also offset by an increase of 5% in ED visits assumed due to the pharmacy carve-out initiative.

***Cost Per Service – Mix/Intensity***

Milliman adjusted the cost per service amounts to reflect changes in the mix / intensity of services due to the management of health care. The cost per service changes were developed following a review of historical managed care encounter data as well as internal sources of information.

***Cost Per Service – Provider Contracting Adjustments***

In addition to the intensity adjustments applied to the cost per service amounts, Milliman also included adjustments to reflect the health plan contracted rates with providers in the managed care adjustments. Milliman reviewed the information provided by the health plans in the reimbursement survey responses as well as the cost information contained on the encounter data. From this review, Milliman developed target percentages of the FFS Medicaid reimbursement rates. The targets reflect a reasonable level of contracting by region resulting from the review of the specific market environments. The target levels do not reflect a prescribed formula such as the weighted average, the arithmetic average, the minimum, or the maximum in each region; however, the targets are generally between the minimum and the maximum levels.



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## IV. DEVELOPMENT OF CY 2008 ADJUSTED ENCOUNTER DATA

### a. Historical Data Summaries

As discussed in other sections of this document, several adjustments were applied to the base encounter data to develop the 2010 calendar year capitation rates. This section outlines each of the adjustments applied to the base encounter data.

Milliman incorporated encounter data for the experience incurred during the 12 months ending December 31, 2007 and December 31, 2008. The encounter data was developed from claims submitted through June 30, 2009.

The claims data was provided by ODJFS from the data warehouse. The experience was stratified into geographic region based on the member's county of residence.

The encounter data represents historical experience for those services that are included in the capitation payment. Services that are not covered under the capitation payment have been excluded from the experience.

### b. Cost per Service

The encounter claim experience contains cost information for the calendar year 2007 and 2008 experience. Milliman summarized the cost per service information into the actuarial model summaries similar to the summarization of the FFS data.

The base cost per service amounts were reviewed for reasonableness as compared to the base FFS experience. Certain sub-capitated claims do not include a financial amount and required an adjustment to the base encounter data to avoid under or over counting the cost per service amounts. Milliman removed the utilization and cost information for these claims and calculated the cost per service amounts by region and category of service for the remaining services. The utilization from all claims, including the claims with invalid cost information, was then applied to the revised cost per service amounts to generate a revised PMPM claim cost amount.

### c. Completion Factors

Milliman utilized 24 months of claims experience for the managed care population that was incurred through December 2008 and submitted to ODJFS through June 30, 2009. Milliman applied claim completion factors to the twelve months of calendar year 2007 and 2008 claims experience.

Milliman additionally included amounts in the *Non-Emergent Transportation* service category that were missing from the encounter base data. This would generally be adjusted as a percentage amount; however, the base encounter data was null for many regions which required an explicit addition of PMPM



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values as opposed to percentage adjustments. Milliman included PMPM values that varied by region based on a review of the health plan submitted cost report and supplemental survey data.

### d. Historical Program Adjustments

The base experience data represents a historical time period from which projections were developed. Certain program changes have occurred during and subsequent to the base data time period. The program adjustments were estimated and applied to the portion of the base experience data prior to the program change effective date. For example, a program change implemented on July 1, 2008 will only be reflected in the second half of CY 2008. As such, an adjustment was applied to all of CY 2007 and half of CY 2008 to include the program change in all periods of the base experience data.

### e. Third-Party Liability and Fraud-Abuse Recoveries

The cost reports and supplemental survey data submitted by the health plans contained information related to third-party liability and fraud-abuse recoveries. Milliman reviewed the reported recoveries and applied the average reduction among plans to all of the base encounter data.

### f. Non-State Plan Services

CMS requires removal of non-state plan services from rate-setting. The encounter data contains certain claims that are considered non-state plan services. The health plan submitted cost reports and supplemental survey data were used as the source of information for the non-state plan service adjustments.

Additionally, Milliman created adjustments to the encounter experience to reflect the reduction in the cost per service for State Plan co-payments that are not reflected in the base experience. These values were calculated from the base FFS experience for each affected category of service.

### g. Historical Selection Adjustments

Milliman applied a historical selection adjustment to the base encounter data to reflect that the base period contains a combination of FFS and managed care enrollment. The historical selection adjustment is intended to normalize the encounter experience to the morbidity level of the entire managed care eligible population.



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### h. Medical Inflation to CY 2008

Milliman developed medical inflation rates to progress the historical experience to a common center point (Midpoint of CY 2008). Due to the timing of the managed care migration, each region contained a member month midpoint that varied from the calendar midpoint due to the timing of the managed care migration.

Milliman developed the medical inflation assumptions following a review of historical experience and internal data sources. The medical inflation rates are not intended to include artificial program adjustments, such as fee schedule changes or benefit modifications. The program adjustments are included in other adjustments in the capitation rate development process.

### i. Blend Base Experience Years

The base experience was trended to the midpoint of CY 2008. At this point, each base year was on a comparable basis and could be aggregated. The weighting was developed with the intention of placing primary credibility on the CY 2008 experience.

### j. Managed Care Adjustments

Utilization and cost per service adjustments were developed for each service category and region.

***Utilization***

Milliman calculated percentage adjustments to the encounter base experience data to reflect the utilization differential between the base experience and the levels targeted for the managed care environment. The sources of information included:

- State of Ohio specific policies and provider environment;
- Historical managed care experience by health plan and region;
- Historical fee-for-service experience;
- NYU Emergency Department Algorithm (ED Only); and,
- Internal research and actuarial judgment.

The managed care utilization adjustments were developed in an iterative process and did not follow a prescribed formula. The general steps followed are outlined below:

- Calculate the adjustments implied by the historical managed care experience as compared to the FFS experience by region and category of service;



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- Review the resulting adjustments for reasonableness and identify categories of service outside of the expected range; and,
- Develop specific adjustments for service categories outside of expected range by reviewing health plan specific experience as well as other sources of information.

**ED Adjustments:** Specifically for the emergency department (ED) service category, Milliman reviewed the resulting classification of claims using the NYU Center for Health and Public Service Research (CHPSR) ED Algorithm. The tool classifies ED utilization into four (4) primary categories as well as categories that are excluded from the grouping. The four categories include: Non-emergent, Emergent/Primary Care Treatable, Emergent–Preventable/Avoidable, and Emergent–Not Preventable/Avoidable. Subsequent to the review of the experience into these defined categories, Milliman developed specific adjustments for the first three categories to reflect the target utilization levels for the managed care plans. The following illustrates the adjustments by ED classification:

- Non-emergent – 50% Reduction
- Emergent/Primary Care Treatable – 33% Reduction
- Emergent – Preventable/Avoidable – 10% Reduction

Further, 75% of the ED visits reduced were replaced with an office visit and the reductions were also offset by an increase of 5% in ED visits assumed due to the pharmacy carve-out initiative.

***Cost Per Service – Mix/Intensity***

Milliman adjusted the cost per service amounts to reflect changes in the mix / intensity of services due to the incremental changes in utilization described above. The cost per service changes were developed following a review of historical managed care encounter data as well as internal sources of information.

***Cost Per Service – Provider Contracting Adjustments***

In addition to the intensity adjustments applied to the cost per service amounts, Milliman also included adjustments to reflect the health plan contracted rates with providers in the managed care adjustments. Milliman reviewed the information provided by the health plans in the reimbursement survey responses as well as the cost information contained on the encounter data. From this review, Milliman developed target percentages of the FFS Medicaid reimbursement rates. The targets reflect a reasonable level of contracting by region resulting from the review of the specific market environments. The target levels do not reflect a prescribed formula such as the weighted average, the arithmetic average, the minimum, or the maximum in each region; however, the targets are generally between the minimum and the maximum levels.



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## V. DEVELOPMENT OF CY 2008 ADJUSTED COST REPORT DATA

### a. Historical Data Summaries

As discussed in other sections of this document, several adjustments were applied to the base cost report data to develop the calendar year 2010 capitation rates. This section outlines each of the adjustments applied to the base cost report data.

Milliman incorporated cost report data for the experience incurred during the 12 months ending December 31, 2007 and December 31, 2008.

The historical data summaries for the base cost report experience reflect only region and health plan combinations with sufficient experience to be considered credible.

### b. Completion Factors

The cost reports contained claim experience incurred through December 31, 2008 and paid through December 31, 2008. Milliman reviewed the June 30, 2009 quarterly statutory reserve restatements contained on page 9 of the respective Underwriting and Investment exhibits to determine the amount of understatement or overstatement of reserves as of December 31, 2008.

### c. Historical Program Adjustments

The base experience data represents a historical time period from which projections were developed. Certain program changes have occurred during and subsequent to the base data time period. The program adjustments were estimated and applied to the portion of the base experience data prior to the program change effective date. For example, a program change implemented on July 1, 2008 will only be reflected in the second half of CY 2008. As such, an adjustment was applied to all of CY 2007 and half of CY 2008 to include the program change in all periods of the base experience data.

### d. Third-Party Liability and Fraud-Abuse Recoveries

The cost reports and supplemental survey data submitted by the health plans contained information related to third-party liability and fraud-abuse recoveries. Milliman reviewed the reported recoveries and applied the average reduction among plans to all of the base cost report data.

### e. Non-State Plan Services

CMS requires removal of non-state plan services from rate-setting. The cost report data contains certain claims that are considered non-state plan services. The health plan submitted cost reports and



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supplemental survey data were used as the source of information for the non-state plan service adjustments.

Additionally, Milliman created adjustments to the cost report experience to reflect the reduction in the cost per service for State Plan co-payments that are not reflected in the base experience. These values were calculated from the base FFS experience for each affected category of service.

### f. Historical Selection Adjustments

Milliman applied a historical selection adjustment to the cost report data to reflect that the base period contains a combination of FFS and managed care enrollment. The historical selection adjustment is intended to normalize the cost report experience to the morbidity level of the entire managed care eligible population.

### g. Medical Inflation to CY 2008

Milliman developed medical inflation rates to progress the historical CY 2007 experience forward to a common center point (CY 2008). Milliman applied a composite trend developed from the encounter data annual trends. This methodology was selected since the cost reports are included in total by region and allocated to service categories and rate groups using the proportion observed in the encounter data.

Due to the timing of the managed care migration, each region contained a member month midpoint that varied from the calendar midpoint due to the timing of the managed care migration.

Milliman developed the medical inflation assumptions following a review of historical experience and internal data sources. The medical inflation rates are not intended to include artificial program adjustments, such as fee schedule changes or benefit modifications. The program adjustments are included in other adjustments in the capitation rate development process.

### h. Blend Base Experience Years

The base experience was trended to the midpoint of CY 2008. At this point, each base year was on a comparable basis and could be aggregated. The weighting was developed with the intention of placing primary credibility on the CY 2008 experience.

### i. Managed Care Adjustments

Milliman adjusted the cost report experience data to reflect changes anticipated in the managed care environment. The cost report base experience was adjusted using the same managed care adjustments as the base encounter data.



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Utilization and cost per service adjustments were developed for each service category and region.

## VI. CY 2008 ADJUSTED BASE DATA TO CY 2010 CAPITATION RATES

The adjusted CY 2008 utilization and cost per service rates are trended forward to CY 2010 and adjusted for prospective program changes that will be effective for the CY 2010 contract period. The resulting PMPM establishes the regional adjusted claim cost for the health plans in CY 2010. The non-claim items (administrative cost allowance, sales and use taxes, and the HIC tax) are applied to the adjusted claim cost to develop the CY 2010 capitation rates.

### a. Medical Inflation Adjustments to CY 2010

The medical inflation rates that were used to progress the CY 2008 experience forward to the CY 2010 rating period were developed from the historical experience, the experience from other Medicaid managed care programs, and our actuarial judgment.

### b. Prospective Program Adjustments

The State Fiscal Year 2010/2011 Budget contains several program changes that impacted the development of the capitation rates. The program changes include items such as provider fee changes, benefit changes, and administrative changes. Adjustments to the CY 2008 experience were developed for each item based on its expected impact to the prospective claims cost.

### c. Prospective Selection Adjustment

Milliman adjusted the CY 2008 experience to reflect the expected penetration of managed care in CY 2010.

### d. Clinical Measures Adjustments

Appendix M of the provider agreement between the contracted health plans and ODJFS contains certain clinical measures that each health plan must achieve. The agreement stipulates that, at a minimum, the experience improvement must reduce the discrepancy between the ultimate target and the actual rate by a certain percentage. Milliman developed adjustments to the capitation rates to reflect this required improvement in performance based on the CY 2007 actual results.



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### e. Blend FFS / Encounter / Cost Report

The FFS, encounter, and cost report data sets were projected to CY 2010 and composited to establish the CY 2010 total claims cost. The credibility between data sources was based upon the amount of managed care experience in the base data. The weights between the encounter and cost report data sources reflect the intention to place more reliance upon health plan submitted encounter data. NEC region exhibited un-reconciled data aberrations and the encounter data was selected as the sole managed care data source.

### f. Administrative Allowance

Milliman included an administrative cost allowance in the development of the actuarially sound capitation rates for CY 2010. The administrative cost allowance contains provision for administrative expenses, profit/contingency, and capital/surplus contribution.

Milliman developed the administrative cost allowance separately for the administration expense, profit/contingency, and capital/surplus contribution components. The administration PMPM was calculated by trending the CY 2009 administration PMPM and re-allocating certain pharmacy administration amounts to the medical categories to reflect the removal of pharmacy from the capitation rate covered services.

The reallocation of pharmacy administration reflects that the administrative component for the medical categories differs from that of the pharmacy category despite the historical methodology of using a uniform percentage across all service categories.

The trend rate assumed for the administration PMPM was developed following a review of the current Employment Cost Index and the CPI-U Index published by the Bureau of Labor Statistics as well as the historical administrative trends for Medicaid health plans in other states.

The profit/contingency and capital/surplus contribution components are a direct percentage of the pre-tax capitation rate due to the nature of these items.

For health plans in plan year 3 or later, 1% of the pre-tax capitation rate will be at-risk and contingent upon performance requirements defined in the ODJFS provider agreements. Additionally, all plans will be eligible for a pharmacy incentive bonus of 0.25% included in the capitation rates. The specific requirements for the Pharmacy Incentive Bonus will be included in the provider agreements.

### g. Sales and Use Tax and HIC Tax

Milliman included a Sales and Use tax and Health Insuring Corporation (HIC) tax component in the development of the actuarially sound capitation rates for CY 2010. The taxes were calculated as a percentage of the capitation rates.



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## VII. CDPS+RX RISK ADJUSTMENT

The methodology described in this document was used to develop the base capitation rates for CY 2010 for each region. Milliman will then apply the Chronic Illness and Disability Payment System (CDPS) to adjust the actuarially sound base capitation rates for the ABD population on a regional basis for each MCP. Milliman will use the CDPS+Rx 5.1 version of the grouper. CDPS+Rx 5.1 is the revised version of CDPS which includes updated diagnostic information as well as Medicaid Rx functionality.

The CDPS+Rx risk adjustment will be updated each six month period for existing regions and plans. For the initial period of managed care within a region and plan, a monthly risk score will be developed for the first three months.

If you have any questions regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures



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# ENCLOSURE 1



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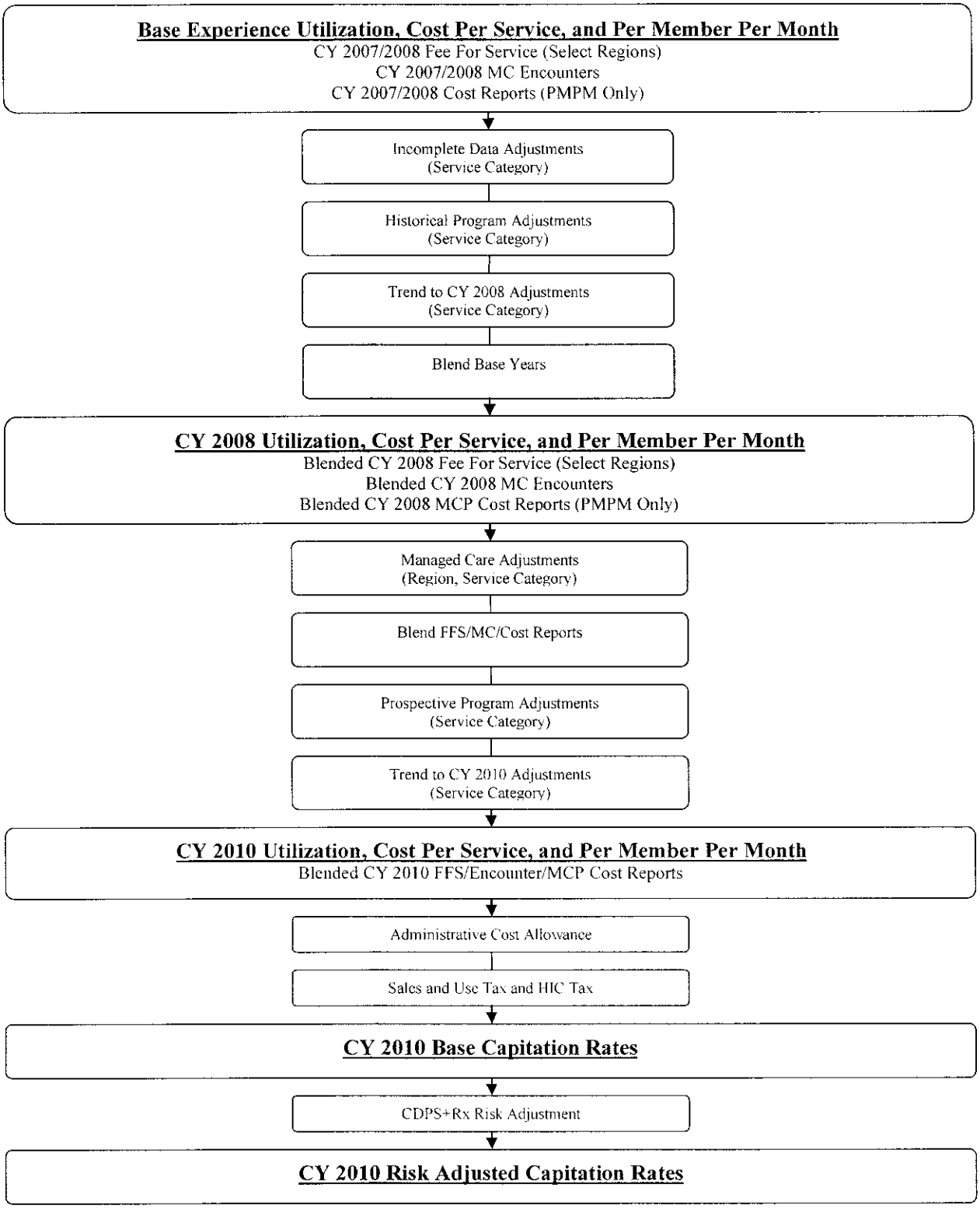




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**STATE OF OHIO**
**DEPARTMENT OF JOB AND FAMILY SERVICES**
**Aged, Blind, or Disabled – CY 2010 Capitation Rates**

**Actuarial Certification**

I, Robert M. Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I was retained by the State of Ohio, Department of Job and Family Services to perform an actuarial review and certification regarding the development of the capitation rates to be effective for calendar year 2010. The capitation rates were developed for the Aged, Blind, or Disabled managed care eligible populations. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion.

I reviewed the historical claims experience for reasonableness and consistency. I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods. I have complied with the elements of the rate setting checklist CMS developed for its Regional Offices regarding 42 CFR 438.6(c) for capitated Medicaid managed care plans.

The capitation rates provided with this certification are effective for a one-year rating period beginning January 1, 2010 through December 31, 2010. At the end of the one-year period, the capitation rates will be updated for calendar year 2011. The update may be based on fee-for-service experience, managed care utilization and trend experience, policy and procedure changes, and other changes in the health care market. A separate certification will be provided with the updated rates.

The capitation rates provided with this certification are considered actuarially sound, defined as:

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

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Robert M. Damler

Robert M. Damler, FSA
Member, American Academy of Actuaries

December 9, 2009
Date

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# ENCLOSURE 3



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# State of Ohio
# Department of Job and Family Services
# Capitation Rate Summary

| Region | Projected CY 2010 Member Months | CY 2010 Guaranteed Rate | CY 2010 At Risk Rate | CY 2010 Rx Incentive Bonus | CY 2010 Rate |
|---|---|---|---|---|---|
| Central | 282,073 | $ 965.12 | $ 9.00 | $ 2.25 | $ 976.37 |
| East Central | 147,107 | $ 884.05 | 8.27 | $ 2.07 | 894.39 |
| Northeast | 278,148 | $ 1,029.60 | 9.54 | $ 2.38 | 1,041.52 |
| Northeast Central | 86,610 | $ 922.79 | 8.61 | $ 2.15 | 933.55 |
| Northwest | 135,675 | $ 1,020.19 | 9.52 | $ 2.38 | 1,032.09 |
| Southeast | 155,795 | $ 752.87 | 7.01 | $ 1.75 | 761.63 |
| Southwest | 174,220 | $ 957.88 | 8.96 | $ 2.24 | 969.08 |
| West Central | 126,778 | $ 952.26 | 8.87 | $ 2.22 | 963.35 |
| Statewide | 1,386,406 | $ 946.26 | 8.82 | $ 2.20 | $ 957.28 |

**MCP:**

# APPENDIX F

## CFC REGIONAL RATES

Please refer to Appendix E of the Provider Agreement to review the specific rates for this time period.

An at-risk amount of 1% is applied to the MCP rates for use in the P4P Incentive System, and a pharmacy incentive bonus of 0.25% is at-risk and applied to the MCP rates for use in the P4P Pharmacy Carve-Out Incentive System, the status of which is determined in accordance with Appendix O, *Pay-for-Performance (P4P).*

Effective through SFY 2010, MCPs will be put at-risk for a portion of the premiums received for members in regions they serve beginning with the MCP's twenty-fifth month ~~of~~ with membership in each region. Effective beginning SFY 2011, MCPs will be put at-risk for a portion of the premiums received for members in regions they serve beginning with the MCP's twenty-fifth month with membership in the Ohio Medicaid CFC Managed Care Program. The at-risk amounts will be determined separately for each region that an MCP serves.

MCP regions at-risk:

# APPENDIX F

# ABD REGIONAL RATES

PREMIUM RATES WITH AT-RISK AMOUNTS

An at-risk amount of 1% is applied to the MCP rates for use in the P4P Incentive System, and a pharmacy incentive bonus of 0.25% is at-risk and applied to the MCP rates for use in the P4P Pharmacy Carve-Out Incentive System, the status of which is determined in accordance with Appendix O, *Pay-for-Performance (P4P).*

Effective through SFY 2010, MCPs will be put at-risk for a portion of the premiums received for members in regions they serve beginning with the MCP's twenty-fifth month ~~of~~ with membership in each region. Effective beginning SFY 2011, MCPs will be put at-risk for a portion of the premiums received for members in regions they serve beginning with the MCP's twenty-fifth month with membership in the Ohio Medicaid ABD Managed Care Program. The at-risk amounts will be determined separately for each region that an MCP serves and will be shared with individual plans through the plan specific ABD rate letters prepared by the ODJFS actuary.

Should the amounts of the premium at-risk change due to plan specific risk adjusted rates, ODJFS will notify the MCP through the risk adjusted plan specific letters prepared by the state's actuary and the new at-risk amounts shall be incorporated into this provider agreement without further process or execution.

# APPENDIX G

# COVERAGE AND SERVICES

1. Basic Benefit Package

Pursuant to OAC rule 5101:3-26-03(A), with limited exclusions, limitations and clarifications (see OAC rule 5101:3-26-03(H) and section G.2 of this appendix), MCPs must ensure that members have access to medically-necessary services covered by the Ohio Medicaid fee-for-service (FFS) program, and any additional services as specified in OAC rule 5101:3-26-03. For information on Medicaid-covered services, MCPs must refer to the ODJFS website. The following is a general list of services covered through the MCP benefit package:

- 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
- Prescription drugs administered in a provider setting pursuant to OAC Chapter 5101:3-9.

- Ambulance and ambulette services
- Dental services
- Durable medical equipment and medical supplies, except for certain medical supplies billed by Ohio Medicaid primary pharmacy providers and covered by the Ohio Medicaid program as described in Appendix A to OAC rule 5101:3-9-02
- Vision care services, including eyeglasses
- Nursing facility stays as specified in OAC rule 5101:3-26-03, including Medicaid-covered prescribed over-the-counter drugs not separately billed to Medicaid fee-for-service, pursuant to OAC rule 5101:3-9-03.
- Hospice care
- Behavioral health services (see section G.2.b.iii of this appendix)
- Immunizations (*MCPs must follow the coverage requirements provided by ODJFS for any newly approved vaccine under the Vaccines for Children (VFC) program)

2. Exclusions, Limitations and Clarifications

a. Exclusions

MCPs are not required to pay for FFS program non-covered services, except as specified in OAC rule 5101:3-26-03. For information regarding Medicaid noncovered services, MCPs must refer to the ODJFS website. The following is a general list of the services not covered by the FFS program:

- Services or supplies that are not 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*
- Treatment of obesity unless medically necessary*
- Custodial or supportive care not covered by Medicaid
- Sexual or marriage counseling
- Acupuncture and biofeedback services
- Services to find cause of death (autopsy) or services related to forensic studies.
- Comfort items in the hospital (e.g., TV or phone)
- Paternity testing
- Services determined by another third-party payor as not medically necessary.
- Assisted suicide which are services for the purpose of causing, or assisting to cause, the death of an individual. This does not pertain to withholding or withdrawing of medical treatment of care, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death.
- Patient convenience items, including television services.

MCPs are also not required to pay for non-emergency services or supplies received without members following the directions in their MCP member handbook, unless otherwise directed by ODJFS.

*****These services could be deemed medically necessary if medical complications/conditions in addition to the obesity or physical imperfection are present.

b. Limitations & Clarifications

i. Member Cost-Sharing

As specified in OAC rules 5101:3-26-05(D) and 5101:3-26-12, MCPs are permitted to impose the applicable member co-payment amount(s) for dental services, vision services, non-emergency emergency department services. MCPs must notify ODJFS if they intend to impose a co-payment. ODJFS must approve the notice to be sent to the MCP's members and the timing of when the co-payments will begin to be imposed. If ODJFS determines that an MCP's decision to impose a particular co-payment on their members would constitute a significant

change for those members, ODJFS may require the effective date of the co-payment to coincide with the "Open Enrollment" month.

Notwithstanding the preceding paragraph, MCPs must provide an ODJFS-approved notice to all their members 90 days in advance of the date that the MCP will impose the co-payment. With the exception of member co-payments the MCP has elected to implement in accordance with OAC rules 5101:3-26-05(D) and 5101:3-26-12, the MCP's payment constitutes payment in full for any covered services and their subcontractors must not charge members or ODJFS any additional co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise.

ii. Abortion and Sterilization

The use of federal funds to pay for abortion and sterilization services is prohibited unless the specific criteria found in 42 CFR 441 and OAC rules 5101:3-17-01 and 5101:3-21-01 are met. MCPs must verify that all of the information on the required forms (JFS 03197, 03198, and 03199) 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. MCPs are responsible for educating their providers on the requirements; implementing internal procedures including systems edits to ensure that claims are only paid once the MCP has determined if the applicable forms are completed and the required criteria are met, as confirmed by the appropriate certification/consent forms; and for maintaining documentation to justify any such claim payments. If MCPs have 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

Coordination of Services: MCPs must ensure that members have access to all medically-necessary behavioral health services covered by the FFS program and are responsible for coordinating those services with other medical and support services, including the publicly funded community behavioral health system. There are a number of Medicaid-covered mental health services available through ODMH Community Mental Health Centers (CMHCs) and Medicaid-covered substance abuse services available through Ohio Department of Alcohol and Drug Addiction Services (ODADAS)-certified Medicaid providers. MCPs must notify members via the member handbook and provider directory of where and how to access behavioral health services, including the ability to self-refer to mental

health services offered through ODMH CMHCs as well as substance abuse services offered through ODADAS-certified Medicaid providers.

MCPs must provide Medicaid-covered behavioral health services for members who are unable to timely access services or are unwilling to access services through the publicly funded community behavioral health system as specified below.

Financial Responsibility for Behavioral Health Services: MCPs are responsible for the following:

- Medicaid-covered services provided by an MCP's panel laboratory when referred by an ODMH CMHC or ODADAS-certified provider;

- Long-acting injectable 2nd generation antipsychotic drugs (e.g., Risperdal, Invega, Zyprexa) covered by Medicaid and administered by an ODMH CMHC.

- Physician services in an IMD as long as the member is 21 years of age and under or 65 years of age and older.

- The following Medicaid-covered behavioral health services obtained through providers other than those who are ODMH CMHCs or ODADAS-certified providers when arranged/authorized by the MCP:

  Mental Health: MCPs are responsible for ensuring access to counseling and psychotherapy, physician/psychologist/psychiatrist services, outpatient clinic services, general hospital outpatient psychiatric services, pre-hospitalization screening, diagnostic assessment (clinical evaluation), crisis intervention, psychiatric hospitalization in general hospitals (for all ages) and laboratory services.

  Substance Abuse: MCPs are responsible for ensuring access to alcohol and other drug (AOD) urinalysis screening, assessment, counseling, physician/psychologist/psychiatrist AOD treatment services, outpatient clinic AOD treatment services, general hospital outpatient AOD treatment services, crisis intervention, inpatient detoxification services in a general hospital, and laboratory services.

Limitations:

- Pursuant to ORC Section 5111.16, alcohol, drug addiction and mental health services covered by Medicaid are not to be paid by the managed care program when the non-federal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other

than ODJFS. As part of this limitation:

- MCPs are not responsible for paying for behavioral health services provided through ODMH CMHCs and ODADAS-certified Medicaid providers;

- MCPs are not responsible for payment of partial hospitalization (mental health), inpatient psychiatric care in a private or public free-standing psychiatric hospital, outpatient detoxification, substance abuse intensive outpatient programs (IOP) or methadone maintenance; and

- MCPs are 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.

iv. Organ Transplants: MCPs must ensure coverage for organ transplants and related services in accordance with OAC 5101-3-2- 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 ODJFS prior authorization unit. Reimbursement for bone marrow transplant and hematapoietic stem cell transplant services, as defined in OAC 3701:84-01, is contingent upon review and recommendation by the "Ohio Hematapoietic Stem Cell Transplant Consortium" again based on criteria established by Ohio experts in the field of bone marrow transplant. While MCPs may require prior authorization for these transplant services, the approval criteria would be limited to confirming the consumer is being considered and/or has been recommended for a transplant by either consortium and authorized by ODJFS. Additionally, in accordance with OAC 5101:3-2-03 (A)(4) all services related to organ donations are covered for the donor recipient when the consumer is Medicaid eligible. MCPs are not responsible for take-home drugs pursuant to OAC rule 5101:3-26-03.

3. Health Management Programs

In an effort to improve access, quality, and continuity of care for MCP members, each MCP must:

i. Establish a primary care provider (PCP) for each member and encourage the member to have an ongoing relationship with the PCP. For this requirement, a PCP as defined in OAC 5101:3-26-01, serves as the ongoing source of primary and preventive care; assists with coordination of care as appropriate for the member's health care needs; recommends referrals to specialists for the member; triages the member appropriately; notifies the MCP of a member who may benefit from care management services; and participates in development of the Care Management care treatment plan. The MCP must ensure the PCP agrees to

perform the care coordination responsibilities as outlined in OAC 5101: 3-26-03.1.

ii. Provide education and outreach to each member to emphasize the importance of disease prevention and health/wellness promotion. The MCP must encourage and enable the member to make informed decisions about accessing and utilizing health care services appropriately.

iii. Direct and monitor coordination of care efforts for each member for medical services delivered across the continuum of care. The MCP should incorporate the requirements in Sections 3 c, d, and e in its overall strategy for care coordination.

iv. Develop and implement a strategy to identify members who display risk factors for developing a disease and/or who over-/under-utilize health care services, and would benefit from targeted outreach or education. For this requirement, the MCP must implement mechanisms to identify such members and should include the following information sources: administrative data review (e.g., pharmacy claims, emergency department claims, or inpatient hospital admissions), provider/self referrals, telephone interviews, home visits, referrals resulting from internal MCP operations, and data as reported by the MCEC during membership selection. Should the MCP identify members characterized as having an increased risk for developing a disease or who inappropriately utilize health care services, the MCP must offer education and outreach initiatives (e.g., educational mailing) designed to mitigate the risk factors, and prevent the member from requiring more progressive interventions, such as care management services.

v. Implement Utilization Management Programs as outlined in Section 3.a. to maximize effectiveness of care provided to members.

vi. Each MCP must implement a Care Management Program as outlined in Section 3.b. which coordinates and monitors the care for members with special health care needs. The Care Management Program must be designed to ensure the intensity of interventions provided by the MCP corresponds to the member's level of need.

a. Utilization Management Programs

General Provisions - Pursuant to OAC rule 5101:3-26-03.1(A)(7), MCPs must implement a utilization management (UM) program to maximize the effectiveness of the care provided to members and may develop other UM programs, subject to prior approval by ODJFS. For the purposes of this requirement, the specific UM programs which require ODJFS prior-approval are an MCP's controlled substances and member management program and any other program designed by the MCP with the purpose of redirecting or restricting access to a particular service or service location.

i. Drug Utilization Management - Pursuant to ORC Sec. 5111.172, MCPs may, subject to ODJFS prior-approval, implement strategies for the management of drug utilization. Pharmacy utilization management strategies may include:

*For prescription drugs covered through the MCP's basic benefit package* - requiring PA of certain drugs and placing limitations on the type of provider and locations where certain drugs may be administered.

*For prescription drugs covered through the MCP's basic benefit package and Ohio Medicaid pharmacy program* - developing and implementing specialized pharmacy programs to address the utilization of controlled substances, as defined in section 3719.01 of the ORC and retrospective drug utilization review programs designed to promote the appropriate clinical prescribing of covered drugs.

Drug Prior Authorizations - MCPs must receive prior approval from ODJFS for the drug classes that they wish to cover through PA. MCPs must establish their PA system so that it does not unnecessarily impede member access to medically-necessary Medicaid-covered services. As outlined in paragraph 29.i.g. of Appendix C, MCPs must adhere to specific PA limitations to assist with the transition of new ABD members from FFS Medicaid.

While MCPs may, with ODJFS approval, require PA for the coverage of 2nd generation antipsychotic drugs, MCPs must allow any member to continue receiving a specific 2nd generation antipsychotic drug if the member is stabilized on that particular medication.

MCPs must comply with the provisions of 1927(d)(5) of the Social Security Act, 42 USC 1396r-8(k)(3), and OAC rule 5101:3-26-03.1 regarding the timeframes for prior authorization of covered outpatient drugs.

Controlled Substances and Member Management Programs: MCPs may also, with ODJFS prior approval, develop and implement Controlled Substances and Member Management (CSMM) programs designed to address use of controlled substances. Utilization management strategies may include PA as a condition of obtaining a controlled substance, as defined in section 3719.01 of the ORC. CSMM strategies may also include processes for requiring MCP members at high risk for fraud or abuse involving controlled substances to have their controlled substances prescribed by designated provider/providers and filled by a

pharmacy, medical provider, or health care facility designated by the program.

ii. Emergency Department Diversion (EDD) – MCPs must provide access to services in a way that assures access to primary, specialist and urgent care in the most appropriate settings and that minimizes frequent, preventable utilization of emergency department (ED) services. OAC rule 5101:3-26-03.1(A)(7)(d) requires MCPs to implement the ODJFS-required EDD program for frequent utilizers.

Each MCP must establish an ED diversion (EDD) program with the goal of minimizing frequent ED utilization. The MCP's EDD program must include the monitoring of ED utilization, identification of frequent ED utilizers, and targeted approaches designed to reduce avoidable ED utilization. MCP EDD programs must, at a minimum, address those ED visits which could have been prevented through improved education, access, quality, or care management approaches.

Although there is often an assumption that frequent ED visits are solely the result of a preference on the part of the member and education is therefore the standard remedy, it is also important to ensure that a member's frequent ED utilization is not due to problems such as their PCP's lack of accessibility or failure to make appropriate specialist referrals. The MCP's EDD program must therefore also include the identification of providers who serve as PCPs for a substantial number of frequent ED utilizers and the implementation of corrective action with these providers as so indicated.

This requirement does not replace the MCP's responsibility to inform and educate all members regarding the appropriate use of the ED.

MCPs must also implement the ODJFS-required EDD program for frequent users. In that ODJFS has developed the parameters for an MCP's EDD program, it therefore does not require ODJFS prior approval.

b. Care Management Programs

In accordance with 5101:3-26-03.1(A)(8), MCPs must offer and provide care management services which coordinate and monitor the care of members with special health care needs.

i. Each MCP must inform all members and contracting providers of the MCP's care management services.

ii. The MCP's care management program must include, at a minimum, the following components:

a. Identification Strategies

The MCP must implement mechanisms to identify members potentially eligible for care management services. These mechanisms must include an administrative data review of pharmacy claims, as available, emergency department visits, and inpatient hospital admissions (e.g. diagnosis, cost threshold, and/or service utilization) and may also include telephone interviews; provider/self-referrals; information as reported by the MCEC during membership selection, home visits, or referrals resulting from internal MCP operations (e.g., utilization management, 24/7 nurse advice line, members services, etc.).

Each MCP must incorporate identification strategies (i.e., mechanisms and criteria) as specified in *ODJFS Care Management Program Requirements.*

b. Risk Stratification Levels

The MCP must develop a strategy to assign members to low, medium, or high-risk stratification levels based on the results of the identification and/or assessment processes. This will be a continual process and the risk levels should be adjusted by the MCP based on the completion of the health assessment and the member's demonstrated progress in meeting the goals of the care treatment plan. Each MCP must incorporate risk stratification levels as specified in *ODJFS Care Management Program Requirements.*

c. Health Assessment

Once a member has been identified by the MCP as being potentially eligible for care management, the MCP must arrange for, or conduct, a health assessment to determine the member's need for care management services. The health assessment completed by the MCP will depend on the member's initial assignment to a low-, medium-, or high-risk stratification level. ODJFS recognizes that the completion of an assessment may result in the assignment of the member to a different risk stratification level (i.e., than the level originally assigned) or that the member may not demonstrate a need for care management services.

For members assigned to the low- or medium-risk stratification levels, the MCP must, at a minimum, complete a health assessment based on a review of administrative claims data. The health assessment must be able to identify the severity of the member's condition/ disease state and must be reviewed by a qualified health professional appropriate for the member's health condition. If an MCP opts to use a disease management methodology/algorithm to assign members to a risk stratification level as part of the assessment, there must be clinical input to the development of the algorithm.

For members assigned to a high risk stratification level, the MCP must complete a health assessment that is comprehensive and evaluates the member's medical condition(s), including physical, behavioral, social, and psychological needs. The health assessment must also evaluate if the member has co-morbidities, or multiple complex health care conditions. The goals of the assessment are to identify the member's existing and/or potential health care needs and assess the member's need for care management services.

The MCP must ensure that the health assessment is completed, or contributed to, by a health care professional(s) who is appropriately qualified for the member's health care condition, follows the state's licensure/credentialing requirements, and operates within the scope of practice as allowed by the state. This applies to the initial and ongoing health assessment performed by MCP staff and for each care management risk stratification level.

The MCP must address the health assessment components as specified in *ODJFS Care Management Program Requirements*.

d. Care Treatment Plan-

The care treatment plan is defined by ODJFS as the one developed by the MCP for the member. The development of the care treatment plan must be based on the health assessment, and reflect the member's health care needs. The care treatment plan must also include specific provisions for periodic reviews of the member's health care needs. Periodic reviews may include administrative data reviews or screening questions to alert the appropriately qualified MCP staff to update the health assessment and the care treatment plan. The frequency of contact with the member must correspond to the member's risk stratification level and must include a provision for two-way communication or feedback between the member and the MCP.

The member and the member's PCP must be actively involved in the development, of and revisions to, the care treatment plan. The designated PCP is the provider, or specialist, who will manage and coordinate the overall care for the member. Ongoing communication regarding the status of the care treatment plan may be accomplished between the MCP and the PCP's designee (i.e., qualified health professional). Revisions to the clinical portion of the care treatment plan should be completed in consultation with the PCP.

The elements of a care treatment plan include:

(a) Goals and actions that address health care conditions identified in the health assessment;

(b) Member level interventions, (i.e., referrals and making appointments) that assist members in obtaining services, providers and programs related to the health care conditions identified in the health assessment; and

(c) Continuous review, revision and contact follow-up, as needed, with members to ensure the care treatment plan is adequately monitored including the following:

- Identification of gaps between recommended care and actual care provided; and
- Re-evaluation of a member's risk stratification level with adjustment to the level of care management services provided.

The MCP must address care treatment plan components as specified in *ODJFS Care Management Program Requirements.*

e. <u>Coordination of Care and Communication</u>

The MCP must assign an accountable point of contact (i.e., care manager) who can help obtain medically necessary care, assist with health-related services and coordinate care needs. The MCP must arrange or provide for professional care management services that are performed collaboratively by a team of professionals appropriate for the member's condition and health care needs. The MCP's care manager must attempt to coordinate with the member's care manager from other health systems. The MCP must have a process to facilitate, maintain, and coordinate both care and communication with the member, PCP, and other service providers and care managers. The MCP must also have a process

to coordinate care for a member that is receiving services from state sub-recipient agencies as appropriate [e.g., the Ohio Department of Mental Health (ODMH); the Ohio Department of Developmental Disabilities (DODD) effective October 5, 2009), and Ohio Department of Alcohol and Drug Addiction Services (ODADAS)]. The MCP must have a provision to disseminate information to the member/caregiver concerning the health condition, types of services that may be available, and how to access services.

f. Member Enrollment in the Care Management Program

The MCP must assure and coordinate the placement of the member into the Care Management Program –including the identification of the member's need for care management services, completion of the health assessment, and timely development of the care treatment plan. This process must occur within the following timeframes for:

a) Newly enrolled members: 90 days from the effective date of enrollment for those members who are identified as meeting the criteria for care management; and
b) Existing members: 90 days from identifying their need for care management.

For members assigned to the low or medium risk stratification levels, the MCP may choose to implement an "opt out" process for members. MCPs that implement an opt out process must provide care management services to the member until the member declines the offer to participate in the program. The opt out process must be clearly defined in all member materials, and the MCP must have a documented process for honoring any opt out requests. For members assigned to a low- or medium-risk level, the MCP may obtain verbal or written confirmation of the member's care management status in the care management records. For members assigned to the high-risk stratification level, the MCP must obtain written or verbal confirmation of the member's care management status in the care management record.

g. Provider and Member Notifications

The MCP must have a process to inform members and their PCPs that they have been identified as meeting the criteria for care management, including their enrollment into the care management program. The MCP must create the following notifications for members enrolled in the care management program:

1. Member Enrollment in the Care Management Program: This must include a description of the opt out process (if an MCP implements) for members in the low- and medium-risk stratification levels; contact information for the member's care manager; and the care management services available to the member.

2. Member Disenrollment from the Care Management Program: This notice must include the rationale for disenrolling the member from the care management program (e.g., declines participation in the program, meets goals in care treatment plan, etc.), and information for the member to contact the MCP if future assistance is needed.

h. Access to Specialists

The MCP must implement mechanisms to notify all Members with Special Health Care Needs of their right to directly access a specialist. Such access may be assured through, for example, a standing referral or an approved number of visits, and documented in the care treatment plan.

i. Care Management Strategies

The MCP must follow best-practice and/or evidence based clinical guidelines when developing interventions for the risk stratification levels, the care treatment plan and coordinating the care management needs. The MCP must develop and implement mechanisms to educate and equip providers and care managers with evidence-based clinical guidelines or best practice approaches to assist in providing a high level of quality of care to members.

j. Care Management Program Staffing

The MCP must identify the staff that will be involved in the operations of the care management program, including but not limited to: care manager supervisors, care managers, and administrative support staff. The MCP must identify the role and functions of each care management staff member as well as the educational requirements, clinical licensure standards, certification and relevant experience with care management standards and/or activities. The MCP must provide care manager staff/member ratios based on the member risk stratification and different levels of care being provided to members.

k. Information Technology System for Care Management Program

The MCP's information technology system for its care management program must maximize the opportunity for

communication between the plan, the PCP, the member, and other service providers and care managers. The MCP must have an integrated database that allows MCP staff that may be contacted by a member in care management to have immediate access to, and review of, the most recent information with the MCP's information systems relevant to the case. The integrated database may include the following: administrative data, call center communications, service authorizations, care treatment plans, patient assessments, care management notes, and PCP notes. The information technology system must also have the capability to share relevant information with the member, the PCP, and other service providers and care managers. The goal is to integrate member information from a variety of sources in an effort to facilitate care management needs.

l. Care Management Data Submission

The MCP must submit a monthly electronic report to the Care Management System (CAMS) for all members who are provided care management services by the MCP as outlined in the *ODJFS Care Management File and Submission Specifications*. In order for a member to be submitted as care managed in CAMS, the MCP must complete the steps as outlined in Section ii.f: Enrollment in the Care Management Program. ODJFS, or its designated entity, the external quality review vendor, will validate on an annual basis the accuracy of the information contained in CAMS with the member's care management record.

The CAMS files are due the 15th calendar day of each month.

The MCP must also have an ODJFS-approved care management program which includes the items in this section. Each MCP must implement an evaluation process to review, revise and/or update the care management program on an annual basis. If the evaluation process results in a revision to identification strategies, health assessment(s), risk stratification strategies, then the MCP must notify ODJFS of the change in writing, which may be subject to review and approval by ODJFS.

c. Care Coordination with ODJFS-Designated Providers

Per OAC rule 5101:3-26-03.1(A)(4), MCPs are required to share specific information with certain ODJFS-designated non-contracting providers in order to ensure that these providers have been supplied with specific information needed to coordinate care for the MCP's members. Once an MCP has obtained a provider agreement, but within the first month of operation, the MCP must provide to the ODJFS-designated providers (i.e.,

ODMH CMHCs, ODADAS-certified Medicaid providers, FQHCs/RHCs, qualified family planning providers [QFPPs], certified nurse midwives [CNMs], certified nurse practitioners [CNPs] [if applicable], and hospitals) a quick reference information packet which includes the following:

i. A brief cover letter explaining the purpose of the mailing; and

ii. A brief summary document that includes the following information:

- Claims submission information including the MCP's Medicaid provider number for each region;
- The MCP's prior authorization and referral procedures or the MCP's website which includes this information;
- A picture of the MCP's member ID card (front and back);
- Contact numbers and/or website location for obtaining information for eligibility verification, claims processing, referrals/prior authorization, post-stabilization care services and information regarding the MCP's behavioral health administrator;
- A listing of the MCP's laboratories and radiology providers; and
- A listing of the MCP's contracting behavioral health providers and how to access services through them (this information is only to be provided to non-contracting community mental health and substance abuse providers).

d. Care coordination with ODJFS pharmacy benefits manager

MCPs are required to send to and receive from the ODJFS pharmacy benefits manager specific information when needed to assure care coordination for members for the receipt of Medicaid-covered services through the ODJFS pharmacy benefit and the MCP benefit package.

e. <u>Care coordination with Non-Contracting Providers</u>

Per OAC rule 5101:3-26-05(A)(9), MCPs authorizing the delivery of services from a provider who does not have an executed subcontract must ensure that they have a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph D of OAC rule 5101:3-26-05. This notice is provided when an MCP authorizes a non-contracting provider to furnish services on a one-time or infrequent basis to an MCP member and must include required ODJFS-model language and information. This notice must also be included with the transition of services form sent to providers as outlined in paragraph 29.h. of Appendix C.

f. Integration of Member Care

The MCP must ensure that a discharge plan is in place to meet a member's health care needs following discharge from a nursing facility, and integrated into the member's continuum of care. The discharge plan must address the services to be provided for the member and must be developed prior to the date of discharge from the nursing facility. The MCP must ensure follow-up contact occurs with the member, or authorized representative, within thirty (30) days of the member's discharge from the nursing facility to ensure that the member's health care needs are being met.

# APPENDIX H

# PROVIDER PANEL SPECIFICATIONS

## 1. GENERAL PROVISIONS

MCPs must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as assure that they meet all applicable provider panel requirements for their entire designated service area. The ODJFS provider panel requirements are specified in the charts included with this appendix and must be met prior to the MCP receiving a provider agreement with ODJFS. The MCP must remain in compliance with these requirements for the duration of the provider agreement.

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

MCPs are **required** to make transportation available to any member requesting transportation when they **must** travel 30 miles or more from their home to receive a medically-necessary Medicaid-covered service. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may **not** be counted toward this trip limit (as specified in Appendix C).

In developing the provider panel requirements, ODJFS considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD and CFC consumers, as well as the potential availability of the designated provider types. ODJFS has integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODJFS requires providers to be located anywhere in the region. Although all provider types listed in this appendix are required provider types, only those listed on the attached charts must be submitted to the Managed Care Provider Network (MCPN).

## 2. PROVIDER SUBCONTRACTING

Unless otherwise specified in this appendix or OAC rule 5101:3-26-05, all MCPs are required to enter into fully-executed subcontracts with their providers. These subcontracts must include a baseline contractual agreement, as well as the appropriate ODJFS-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable OAC rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCP's name.

MCPs must submit for ODJFS review a copy of the complete subcontract, including the Medicaid addendum for all new, subcontracting hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) before they can be listed in the MCPN or the MCP online provider directory. MCPs 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. MCPs must submit documentation verifying that all necessary contract documents have been appropriately completed. ODJFS will verify the submission and process this information using the ODJFS MCPN, maintained by the MCEC, or other designated process. The MCPN is a centralized database system that maintains information on the status of all MCP-submitted providers.

Only those providers who meet the applicable criteria specified in this document, and as determined by ODJFS, will be counted toward meeting minimum panel requirements. MCPs must credential/recredential providers in accordance with OAC rule 5101:3-26-05. The MCP must ensure that the provider has met all applicable credentialing criteria before the provider can render services to the MCP's members.

MCPs must notify ODJFS of the addition and deletion of their contracting providers as specified in OAC rule 5101:3-26-05, and must notify ODJFS within one working day in instances where the MCP has identified that they are not in compliance with the provider panel requirements specified in this appendix.

## 3. PROVIDER PANEL REQUIREMENTS

The provider network criteria that must be met by each MCP are as follows:

### a. Primary Care Providers (PCPs)

PCP means an individual physician (M.D. or D.O.), certain physician group practice/clinic (Primary Care Clinics [PCCs]), or an advanced practice nurse (APN) as defined in ORC 4723.43 or advanced practice nurse group practice within an acceptable specialty, contracting with an MCP to provide services as specified in paragraph (B) of OAC rule 5101: 3-26-03.1. The APN capacity can count up to 10% of the total requirement for the county. Acceptable specialty types for PCPs include family/general practice, internal medicine, pediatrics, and obstetrics/ gynecology (OB/GYN). Acceptable PCCs include FQHCs, RHCs and the acceptable group practices/clinics specified by ODJFS. As part of their subcontract with an MCP, PCPs must stipulate the total Medicaid member capacity that they can ensure for that individual MCP.

Each PCP must have the capacity and agree to serve at least 50 Medicaid MCP members at each practice site in order for the PCP to count toward minimum provider panel requirements.

ODJFS reviews the capacity totals for each PCP to determine if they appear excessive.
ODJFS reserves the right to request clarification from an MCP for any PCP whose total stated capacity for all MCP networks added together exceeds 2000 Medicaid members.
Where indicated, ODJFS may set a cap on the maximum amount of capacity that we will recognize for a specific PCP. ODJFS may allow up to an additional 750 member capacity for each nurse practitioner or physician's assistant that is used to provide clinical support for a PCP.

For PCPs contracting with more than one MCP, the MCP must ensure that the capacity figure stated by the PCP in their subcontract reflects only the capacity the PCP intends to provide for that one MCP. ODJFS utilizes each approved PCP's capacity figure to determine if an MCP meets the provider panel requirements and this stated capacity figure does not prohibit a PCP from actually having a caseload that exceeds the capacity figure indicated in their subcontract.

ODJFS recognizes that MCPs will need to utilize specialty providers to serve as PCPs for some special needs members. In these situations the MCP would submit these specialists to the MCPN database, or other system as PCPs, however they will not count toward minimum provider panel PCP requirements they must be submitted to MCPN, or other system, as the appropriate required provider type and coded as a PCP. Also, in some situations (e.g., continuity of care) a PCP may only want to serve a very small number of members for an MCP. These PCPs will, however, need to execute a subcontract with the MCP which includes the appropriate Model Medicaid Addendum.

The PCP requirement is based on an MCP having sufficient PCP capacity to serve 40% of the eligibles in the region if three MCPs are serving the region and 55% of the eligibles in the region if two MCPs are serving the region. At a minimum, each MCP serving CFC members must meet the PCP capacity requirement for that region, each MCP serving ABD members must meet the PCP capacity requirements and the minimum number of PCP requirements for that region. MCPs must also satisfy a PCP geographic accessibility standard. ODJFS will match the PCP practice sites and the stated PCP capacity with the geographic location of the eligible population in that region (on a county-specific basis) and perform analysis using GIS software. The analysis will be used to determine if at least 40% of the eligible population is located within 10 miles of a PCP with available capacity in urban counties and 40% of the eligible population within 30 miles of a PCP with available capacity in rural counties. Rural areas are defined pursuant to 42 CFR 412.62(f)(1)(iii).

In addition to the PCP capacity requirement, MCPs serving CFC members must also contract with the specified number of pediatric PCPs for each region. These pediatric PCPs will have their stated capacity counted toward the PCP capacity requirement.

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

b. Non-PCP Provider Network

In addition to the PCP capacity requirements, each MCP is also required to maintain adequate capacity in the remainder of its provider network within the following categories: hospitals, dentists, vision care providers, OB/GYNs, allergists, general surgeons, otolaryngologists, orthopedists, FQHCs/RHCs and QFPPs. CNMs, CNPs, FQHCs/RHCs and QFPPs are federally-required provider types.

Each MCP serving ABD members is required to maintain adequate capacity in addition to the remainder of its provider network within the following categories: cardiovascular, gastroenterology, nephrology, neurology, oncology, physical medicine, podiatry, psychiatry, and urology.

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

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

*Hospitals* - MCPs must contract with the number and type of hospitals specified by ODJFS for each county/region. In developing these hospital requirements, ODJFS considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD and CFC consumers and integrated the existing utilization patterns into the hospital network requirements to avoid disruption of care. For this reason, ODJFS may require that MCPs contract with out-of-state hospitals (i.e. Kentucky, West Virginia, etc.).

For each Ohio hospital, ODJFS utilizes the hospital's most current Annual Hospital Registration and Planning Report, as filed with the Ohio Department of Health (ODH), in verifying types of services that hospital provides. Although ODJFS has the authority, under certain situations, to obligate a non-contracting hospital to provide non-emergency hospital services to an MCP's members, MCPs must still contract with the specified number and type of hospitals unless

ODJFS approves a provider panel exception (see Section 4 of this appendix, *Provider Panel Exceptions*).

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

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

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

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

*Vision Care Providers* - MCPs must contract with the specified number of ophthalmologists/ optometrists for each specified county/region, all of whom must maintain a full-time practice at a site(s) located in the specified county/region to count toward minimum panel requirements. All ODJFS-approved vision providers must regularly perform routine eye exams. MCPs will be expected to contract with an adequate number of ophthalmologists as part of their overall provider panel, but only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care provider panel requirement. If optical dispensing is not sufficiently available in a region through the MCP's contracting ophthalmologists/optometrists, the MCP must separately contract with an adequate number of optical dispensers located in the region.

*Dental Care Providers* - MCPs must contract with the specified number of dentists. In order to assure sufficient access to adult CFC MCP members, no more than two-thirds of the dentists used to meet the CFC provider panel requirement may be pediatric dentists.

*FQHCs/RHCs* - MCPs are required to ensure member access to any FQHCs/RHCs, regardless of contracting status. Contracting FQHC/RHC providers must be submitted for ODJFS review via the MCPN process, or other designated process. Even if no FQHC/RHC is available within the

region, MCPs must have mechanisms in place to ensure coverage for FQHC/RHC services in the event that a member accesses these services outside of the region.

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

- MCPs must provide expedited reimbursement on a service-specific basis in an amount no less than the payment made to other providers for the same or similar service.

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

- MCPs must make all efforts to pay FQHCs/RHCs as quickly as possible and not just attempt to pay these claims within the prompt pay time frames.

MCPs are required to educate their staff and providers on the need to assure member access to FQHC/RHC services.

*Qualified Family Planning Providers (QFPPs)* - All MCP members must be permitted to self-refer for services and supplies allowed under Title X of the Public Health Services Act (Title X services) provided by a QFPP. A QFPP is defined as any public or not-for-profit health care provider that complies with Title X guidelines/standards, and receives either Title X funding or family planning funding from the ODH.. MCPs must reimburse all medically-necessary Medicaid-covered Title X services provided to eligible members by a QFPP provider (including on-site pharmacy and diagnostic services) on a patient self-referral basis, regardless of the provider's status as a panel or non-panel provider. A description of Title X services can be found on the ODH website.

MCPs will be required to work with QFPPs in the region to develop mutually-agreeable HIPAA compliant policies and procedures to preserve patient/provider confidentiality, and convey pertinent information to the member's PCP and/or MCP.

*Behavioral Health Providers* – MCPs must assure member access to all Medicaid-covered behavioral health services for members as specified in Appendix G.2. b.iii. herein. Although ODJFS is aware that certain outpatient substance abuse services may only be available through Medicaid providers certified by the ODADAS in some areas, MCPs must maintain an adequate number of contracted mental health providers in the region to assure access for members who are unable to timely access services or unwilling to access services through community mental health centers. MCPs are not to contract with ODMH community mental health centers and /or ODADAS certified alcohol and other drug treatment providers for behavioral health services as the non-federal share of the cost for these services is provided by a board of alcohol, drug addiction and mental health services or a state agency other than ODJFS. MCP members are therefore permitted to self-refer to such providers for carved out services. However, MCPs may contract with medical clinics owned and operated by ODMH community mental health centers

and/or ODADAS alcohol and other drug treatment providers based on MCP business or operational needs (for example, to bolster MCPs provider networks or enhance patient-centered care coordination) for physical health services.

*Other Specialty Types (allergists, pediatricians, general surgeons, otolaryngologists, orthopedists for the CFC population and general surgeons, otolaryngologists, orthopedists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, podiatrists, physiatrists, psychiatrists, and urologists for the ABD population )* - MCPs must contract with the specified number of all other ODJFS designated specialty provider types. In order to be counted toward meeting the provider panel requirements, these specialty providers must maintain a full-time practice at a site(s) located within the specified county/region. Only contracting general surgeons, orthopedists, and otolaryngologists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, physiatrists, and urologists with admitting privileges at a hospital under contract with the MCP in the region can be submitted to the MCPN, or other system, count towards MCP minimum panel requirements, and be listed in the MCP's provider directory.

## 4. PROVIDER PANEL EXCEPTIONS

ODJFS may specify provider panel criteria for a service area that deviates from that specified in this appendix if:

- the MCP presents sufficient documentation to ODJFS to verify that they have been unable to meet or maintain certain provider panel requirements in a particular service area despite all reasonable efforts on their part to secure such a contract(s), and

- if notified by ODJFS, the provider(s) in question fails to provide a reasonable argument why they would not contract with the MCP, and

- the MCP presents sufficient assurances to ODJFS that their members will have adequate access to the services in question.

If an MCP is unable to contract with or maintain a sufficient number of providers to meet the ODJFS-specified provider panel criteria, the MCP may request an exception to these criteria by submitting a provider panel exception request as specified by ODJFS. ODJFS will review the exception request and determine whether the MCP has sufficiently demonstrated that all reasonable efforts were made to obtain contracts with providers of the type in question and that they will be able to provide access to the services in question.

ODJFS may approve a provider panel exception request (PPE) for a period of not more than one year. If there exists an active PPE for a provider panel criteria, ODJFS will not review or approve an additional PPE for that criteria sooner than the month immediately preceding the month in which the existing PPE is set to expire. For example, if there exists a PPE for a dentist in X county that expires January 2010, ODJFS would not review or approve a new PPE for dentist in X county before December 2009. The PPE approval date shall be specified in the ODJFS approval letter. Once the MCP has resolved the deficiency, the PPE is no longer valid.

ODJFS will aggressively monitor access to all services related to the approval of a provider panel exception request through a variety of data sources, including: consumer satisfaction surveys; member appeals/grievances/complaints and state hearing notifications/requests; member just-cause for termination requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures. ODJFS approval of a PPE request does not exempt the MCP from assuring access to the services in question. If ODJFS determines that an MCP has not provided sufficient access to these services, the MCP may be subject to sanctions.

## 5. PROVIDER DIRECTORIES

MCP provider directories must include all MCP-contracted providers [except as specified by ODJFS] as well as certain non-contracted providers. At the time of ODJFS' review, the information listed in the MCP's provider directory for all ODJFS-required provider types specified on the attached charts must exactly match the data currently on file in the ODJFS MCPN, or other designated process.

MCP provider directories must utilize a format specified by ODJFS. Directories 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 receiving a provider agreement, all MCPs must develop a printed provider directory that shall be prior-approved by ODJFS for each covered population. For example, an MCP who serves CFC and ABD in the Central Region would have two provider directories, one for CFC and one for ABD. Once approved, this directory may be regularly updated with provider additions or deletions by the MCP without ODJFS prior-approval, however, copies of the revised directory (or inserts) must be submitted to ODJFS prior to distribution to members.

On a quarterly basis, MCPs **must** create an insert to each printed directory that lists those providers **deleted** from the MCP's provider panel during the previous three months. Although this insert does not need to be prior approved by ODJFS, copies of the insert must be submitted to ODJFS two weeks prior to distribution to members.

**Internet Provider Directory**

MCPs are required to have an internet-based provider directory available in a format prior approved by ODJFS. This internet directory must allow members to electronically search for MCP panel providers based on name, provider type, and geographic proximity. If an MCP 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 ODJFS-required provider types listed on the charts included with this appendix. ODJFS-required providers **must** be added to the internet directory within one week of submitting the provider to the MCPN. Providers being deleted from the MCP's panel must be deleted from the internet directory within one week of notification from the provider to the MCP. Providers being deleted from the MCP's panel must be posted to the internet directory within one week of notification from the provider to the MCP of the deletion. These deleted providers must be included in the inserts to the MCP's printed provider directory referenced above.

## 6. FEDERAL ACCESS STANDARDS

MCPs must demonstrate that they are in compliance with the following federally defined provider panel access standards as required by 42 CFR 438.206:

In establishing and maintaining their provider panel, MCPs 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 MCP.
- 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.
- MCPs must adequately and timely cover services to an out-of-network provider if the MCP's contracted provider panel is unable to provide the services covered under the MCP's provider agreement. The MCP must cover the out-of-network services for as long as the MCP network is unable to provide the services. MCPs 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. MCPs must ensure that services are available 24 hours a day, 7 days a week, when medically necessary. MCPs 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 demonstrate adequate provider panel capacity and services, 42 CFR 438.206 and 438.207 stipulates that the MCP must submit documentation to ODJFS, in a format specified by ODJFS, that demonstrates it offers an appropriate range of preventive, primary care and specialty 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 ODJFS no less frequently than at the time the MCP enters into a contract with ODJFS; at any time there is a significant change (as defined by ODJFS) in the MCP'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 MCP.

## Central Region

| | Crawford | Delaware | Fairfield | Fayette | Franklin | Hocking | Knox | Licking | Logan | Madison | Marion | Morrow | Perry | Pickaway | Pike | Ross | Scioto | Union | Additional Required: In-Region | Total Required |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PCP Capacity - ABD** | | | | | | | | | | | | | | | | | | | | |
| Capacity | 170 | 174 | 395 | 152 | 4,670 | 176 | 211 | 502 | 131 | 104 | 367 | 102 | 243 | 222 | 375 | 543 | 1,196 | 74 | | 9,807 |
| PCPs | 2 | 2 | 3 | 2 | 17 | 2 | 2 | 4 | 2 | 1 | 3 | 1 | 3 | 2 | 3 | 4 | 5 | 1 | | 59 |
| | | | | | | | | | | | | | | | | | | | | |
| **PCP Capacity - CFC** | | | | | | | | | | | | | | | | | | | | |
| Capacity | 2,016 | 2,307 | 4,698 | 1,341 | 55,101 | 1,672 | 2,236 | 5,897 | 1,656 | 1,378 | 3,042 | 1,492 | 2,263 | 2,123 | 2,116 | 4,442 | 5,204 | 1,269 | | 100,253 |

*Any additional CFC required capacity must be located within the region.

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hospitals - ABD** | | | | | | | | | | | | | | | | | | | | |
| General Hospital | | | 1 | 1 | | | | 1 | | | 1 | | | 1 | | 1 | 1 | | 3 | 10 |
| Hospital System | | | | | 2 | | | | | | | | | | | | | | | 2 |
| | | | | | | | | | | | | | | | | | | | | |
| **Hospitals - CFC** | | | | | | | | | | | | | | | | | | | | |
| General Hospital | 1 | | 1 | 1 | 1 | | 1 | 1 | 1 | 1 | 1 | | | 1 | | 1 | 1 | 1 | 1 | 14 |
| Hospital System | | | | | 2 | | | | | | | | | | | | | | | 2 |

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.
*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.
*CFC Franklin county general hospital must include one hundred fifty (150) pediatric beds and twenty-five (25) pediatric intensive care unit (PICU) beds.
*Genesis Health Care System, Inc. is the additional CFC required general hospital.

**Practitioners - ABD**

## Central Region

| | Crawford | Delaware | Fairfield | Fayette | Franklin | Hocking | Knox | Licking | Logan | Madison | Marion | Morrow | Perry | Pickaway | Pike | Ross | Scioto | Union | Additional Required: In-Region | Total Required |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cardiovascular | | | | | 2 | | | | | | | | | | | | | | 3 | 5 |
| Dentists | | 1 | 1 | | 15 | | 1 | 1 | | | 1 | | | | | 1 | | | | 21 |
| Gastroenterology | | | | | 1 | | | | | | | | | | | | | | 2 | 3 |
| General Surgeons | | 1 | 1 | | 5 | | | | | | | | | | | 1 | 1 | | 1 | 10 |
| Nephrology | | | | | 1 | | | | | | | | | | | | | | 1 | 2 |
| Neurology | | | | | 1 | | | | | | | | | | | | | | 2 | 3 |
| OB/GYNs | | 1 | 1 | | 6 | | | | | | | | | | | | | | 2 | 10 |
| Oncology | | | | | | | | | | | | | | | | | | | 1 | 1 |
| Orthopedists | | | 1 | | 3 | | | 1 | | | 1 | | | | | 1 | | | | 7 |
| Otolaryngologist | | 1 | | | 2 | | | | | | | | | | | | | | | 3 |
| Physical Med Rehab | | | | | 1 | | | | | | | | | | | | | | 2 | 3 |
| Podiatry | | 1 | | | 3 | | | | | | | | | | | | | | 3 | 7 |
| Psychiatry | | | 1 | | 5 | | | | | | | | | | | | | | 4 | 10 |
| Urology | | | | | | | | | | | | | | | | | | | 4 | 4 |
| Vision | 1 | 1 | 1 | | 5 | | 1 | 1 | 1 | | 1 | | | | | 1 | 1 | | | 14 |

*All required providers and additional required providers must be located within the region.

**Practitioners - CFC**

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pediatricians | | 4 | 3 | | 55 | | 1 | 2 | 1 | 1 | 2 | | | 1 | | 2 | 2 | 1 | 11 | 86 |
| OB/GYNs | | 2 | 2 | | 12 | | 1 | 1 | | | 1 | | | | | 1 | 1 | | 3 | 24 |
| Vision | 1 | 2 | 2 | | 15 | | 1 | 1 | 1 | | 1 | | | 1 | | 1 | 1 | 1 | 3 | 31 |
| General Surgeons | 1 | 1 | 1 | | 10 | | 1 | 1 | 1 | | 1 | | | | | 1 | 1 | 1 | 2 | 22 |
| Otolaryngologist | | 1 | | | 4 | | | | | | | | | | | | | | 1 | 6 |
| Allergists | | | | | 2 | | | | | | | | | | | | | | 2 | 4 |
| Orthopedists | | | 1 | | 7 | | | 1 | | | 1 | | | | | 1 | | | 2 | 13 |
| Dentists | 1 | 2 | 3 | 1 | 45 | 1 | 2 | 3 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 3 | 2 | 1 | 5 | 77 |

*All required providers and additional required providers must be located within the region.
*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

# East Central Region

| | Ashland | Carroll | Holmes | Portage | Richland | Stark | Summit | Tuscarawas | Wayne | Additional Required: In-Region | Total Required |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **PCP Capacity - ABD** | | | | | | | | | | | |
| Capacity | 106 | 97 | 57 | 327 | 530 | 1,332 | 2,121 | 327 | 357 | | 5,254 |
| PCPs | 1 | 1 | 1 | 2 | 3 | 4 | 5 | 2 | 2 | | 21 |
| | | | | | | | | | | | |
| **PCP Capacity - CFC** | | | | | | | | | | | |
| Capacity | 1,732 | 1,226 | 794 | 4,329 | 5,363 | 14,376 | 20,279 | 3,616 | 3,291 | | 55,006 |

*Any additional CFC required capacity must be located within the region.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hospitals - ABD** | | | | | | | | | | | |
| General Hospital | | | | 1 | 1 | 1 | | 1 | 1 | 2 | 7 |
| Hospital System | | | | | | | 1 | | | | 1 |
| | | | | | | | | | | | |
| **Hospitals - CFC** | | | | | | | | | | | |
| General Hospital | 1 | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | 8 |
| Hospital System | | | | | | | 1 | | | | 1 |

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.

*CFC Summit county general hospital must be a hospital that includes one hundred (100) pediatric beds and five (5) pediatric intensive care unit (PICU) beds.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Practitioners - ABD** | | | | | | | | | | | |
| Cardiovascular | | | | | | 1 | 1 | | | 1 | 3 |

## East Central Region

| | Ashland | Carroll | Holmes | Portage | Richland | Stark | Summit | Tuscarawas | Wayne | Additional Required: In-Region | Total Required |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Dentists | 1 | | | | 2 | 4 | 6 | 1 | | | 14 |
| Gastroenterology | | | | | | | | | | 2 | 2 |
| General Surgeons | | | | | 1 | 1 | 2 | | 1 | 2 | 7 |
| Nephrology | | | | | | | | | | 1 | 1 |
| Neurology | | | | | | | | | | 2 | 2 |
| OB/GYNs | | | | | | 2 | 4 | | | | 6 |
| Oncology | | | | | | | | | | 1 | 1 |
| Orthopedists | | | | | | 1 | 1 | | | 2 | 4 |
| Otolaryngologist | | | | | | 1 | 1 | | | | 2 |
| Physical Med Rehab | | | | | | | | | | 2 | 2 |
| Podiatry | | | | | | 1 | 2 | | | 1 | 4 |
| Psychiatry | | | | | | 2 | 3 | | | 1 | 6 |
| Urology | | | | | | | | | | 2 | 2 |
| Vision | | | | | 1 | 2 | 3 | | | 2 | 8 |

*All required providers and additional required providers must be located within the region.

**Practitioners - CFC**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Pediatricians | 1 | | | 2 | 3 | 14 | 20 | 2 | 2 | 5 | 49 |
| OB/GYNs | | | | | 1 | 5 | 8 | | 1 | 2 | 17 |
| Vision | | | | | 1 | 5 | 8 | | | 4 | 18 |
| General Surgeons | | | | 1 | 2 | 3 | 4 | 1 | 1 | 1 | 13 |
| Otolaryngologist | | | | | | 2 | 2 | | | 3 | 7 |
| Allergists | | | | | | 1 | 1 | | | 1 | 3 |
| Orthopedists | | | | | 1 | 2 | 2 | | 1 | 3 | 9 |
| Dentists | 2 | | | 3 | 5 | 13 | 17 | 3 | 3 | 2 | 48 |

*All required providers and additional required providers must be located within the region.

*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

## Northeast Region

| | Ashtabula | Cuyahoga | Erie | Geauga | Huron | Lake | Lorain | Medina | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **PCP Capacity - ABD** | | | | | | | | | | |
| Capacity | 585 | 7,370 | 213 | 85 | 173 | 385 | 990 | 180 | | 9,981 |
| PCPs | 4 | 16 | 2 | 1 | 1 | 2 | 4 | 1 | | 31 |
| | | | | | | | | | | |
| **PCP Capacity - CFC** | | | | | | | | | | |
| Capacity | 5,256 | 66,564 | 2,873 | 1,111 | 2,612 | 5,210 | 11,431 | 3,155 | | 98,212 |
| *Any additional required CFC capacity must be located within the region. | | | | | | | | | | |
| **Hospitals - ABD** | | | | | | | | | | |
| General Hospital | 1 | | | 1 | 1 | 1 | 1 | 1 | | 6 |
| Hospital System | | 1 | | | | | | | 1 | 2 |
| | | | | | | | | | | |
| **Hospitals - CFC** | | | | | | | | | | |
| General Hospital | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | 8 |
| Hospital System | | 1 | | | | | | | | 1 |
| *ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements. *CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region. *The Cuyahoga CFC general hospital requirement may be met by either contracting with (1) that includes fifty (50) pediatric beds and five (5) pediatric intensive care unit (PICU) beds OR (2) a single general hospital that includes fifty (50) pediatric beds and five (5) pediatric intensive care unit (PICU) beds and a hospital system. | | | | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Practitioners - ABD** | | | | | | | | | | |
| Cardiovascular | | 3 | | | | | 1 | | 2 | 6 |

## Northeast Region

| | Ashtabula | Cuyahoga | Erie | Geauga | Huron | Lake | Lorain | Medina | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Dentists | 1 | 20 | | | | 2 | 3 | 1 | 1 | 28 |
| Gastroenterology | | 2 | | | | | | | 1 | 3 |
| General Surgeons | | 6 | 1 | | 1 | 1 | 1 | 1 | | 11 |
| Nephrology | | 1 | | | | | | | 1 | 2 |
| Neurology | | 2 | | | | | | | 1 | 3 |
| OB/GYNs | | 8 | 1 | | | | 1 | | 2 | 12 |
| Oncology | | | | | | | | | 1 | 1 |
| Orthopedists | | 4 | | | | | 1 | | 2 | 7 |
| Otolaryngologist | | 1 | | | | | 1 | | 1 | 3 |
| Physical Med Rehab | | 2 | | | | | | | 1 | 3 |
| Podiatry | | 4 | | | | | 2 | | 2 | 8 |
| Psychiatry | | 5 | | | | | 3 | | 3 | 11 |
| Urology | | 2 | | | | | | | 2 | 4 |
| Vision | 1 | 7 | 1 | | | 1 | 1 | | 3 | 14 |
| *All required providers and additional required providers must be located within the region. | | | | | | | | | | |
| | | | | | | | | | | |
| **Practitioners - CFC** | | | | | | | | | | |
| Pediatricians | 1 | 66 | 2 | | | 3 | 8 | 3 | 7 | 90 |
| OB/GYNs | 1 | 16 | 1 | | 1 | 1 | 2 | 1 | 2 | 25 |
| Vision | 1 | 25 | 1 | | | 1 | 2 | 1 | 2 | 33 |
| General Surgeons | | 12 | 1 | | 1 | 1 | 2 | 1 | 2 | 20 |
| Otolaryngologist | | 2 | | | | | 1 | | 3 | 6 |
| Allergists | | 2 | | | | | 1 | | 2 | 5 |
| Orthopedists | | 8 | 1 | | | 1 | 2 | 1 | 3 | 16 |
| Dentists | 2 | 65 | 1 | 1 | 1 | 5 | 10 | 3 | 1 | 89 |
| *All required providers and additional required providers must be located within the region. | | | | | | | | | | |
| *Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists. | | | | | | | | | | |

## Northeast Central Region

| | Columbiana | Mahoning | Trumbull | Additional Required: In-Region | Total |
|---|---|---|---|---|---|
| **PCP Capacity - ABD** | | | | | |
| Capacity | 582 | 1,440 | 1,007 | | 3,029 |
| PCPs | 3 | 4 | 4 | | 11 |
| | | | | | |
| **PCP Capacity - CFC** | | | | | |
| Capacity | 5,281 | 12,039 | 9,047 | 5,000 | 31,367 |

*Any additional required CFC capacity must be located within the region.

| | | | | | |
|---|---|---|---|---|---|
| **Hospitals - ABD** | | | | | |
| General Hospital | 1 | 1 | 1 | | 3 |
| Hospital System | 0 | 0 | 0 | | 0 |
| | | | | | |
| **Hospitals - CFC** | | | | | |
| General Hospital | 1 | 1 | 1 | | 3 |
| Hospital System | 0 | 0 | 0 | | 0 |

*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.

*Mahoning county CFC general hospital must be a hospital that includes thrity (30) pediatric beds and five (5) pediatric intensive care unit (PICU) beds.

| | | | | | |
|---|---|---|---|---|---|
| **Practitioners - ABD** | | | | | |
| Cardiovascular | | 1 | | 1 | 2 |
| Dentists | 1 | 3 | 3 | | 7 |

## Northeast Central Region

| | Columbiana | Mahoning | Trumbull | Additional Required: In-Region | Total |
|---|---|---|---|---|---|
| Gastroenterology | | | | 1 | 1 |
| General Surgeons | 1 | 1 | 1 | | 3 |
| Nephrology | | | | 1 | 1 |
| Neurology | | | | 1 | 1 |
| OB/GYNs | 1 | 1 | 1 | 1 | 4 |
| Oncology | | | | 1 | 1 |
| Orthopedists | | 1 | | 1 | 2 |
| Otolaryngologist | | 1 | | | 1 |
| Physical Med Rehab | | | | 1 | 1 |
| Podiatry | | | | 1 | 1 |
| Psychiatry | | 3 | 2 | 1 | 6 |
| Urology | | | | 1 | 1 |
| Vision | | 2 | 2 | 1 | 5 |
| *All required providers and additional required providers must be located within the region. | | | | | |
| **Practitioners - CFC** | | | | | |
| Pediatricians | 2 | 10 | 6 | 5 | 23 |
| OB/GYNs | 1 | 3 | 2 | 1 | 7 |
| Vision | | 3 | 2 | 2 | 7 |
| General Surgeons | 1 | 3 | 1 | 1 | 6 |
| Otolaryngologist | | 1 | | 1 | 2 |
| Allergists | | | | 1 | 1 |
| Orthopedists | | 2 | 1 | 1 | 4 |
| Dentists | 2 | 11 | 8 | 2 | 23 |
| *All required providers and additional required providers must be located within the region.<br>*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists. | | | | | |

# Northwest Region

| | Allen | Auglaize | Defiance | Fulton | Hancock | Hardin | Henry | Lucas | Mercer | Ottawa | Paulding | Putnam | Sandusky | Seneca | Van Wert | Williams | Wood | Wyandot | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PCP Capacity - ABD** | | | | | | | | | | | | | | | | | | | | |
| Capacity | 400 | 66 | 102 | 71 | 152 | 127 | 40 | 2,833 | 65 | 85 | 68 | 44 | 166 | 179 | 70 | 91 | 170 | 40 | | 4,769 |
| PCPs | 3 | 1 | 1 | 1 | 2 | 2 | 1 | 9 | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 1 | 2 | 1 | | 33 |
| | | | | | | | | | | | | | | | | | | | | |
| **PCP Capacity - CFC** | | | | | | | | | | | | | | | | | | | | |
| Capacity | 4,262 | 1,228 | 1,555 | 1,270 | 2,038 | 1,096 | 894 | 24,752 | 821 | 1,271 | 710 | 770 | 2,142 | 2,128 | 847 | 1,478 | 2,444 | 634 | 18,200 | 68,540 |

*Any additional required CFC capacity must be located within the region.

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hospitals - ABD** | | | | | | | | | | | | | | | | | | | | |
| General Hospital | 1 | | 1 | | 1 | | | | | | | | 1 | | | | | | 3 | 7 |
| Hospital System | | | | | | | | 1 | | | | | | | | | | | | 1 |
| | | | | | | | | | | | | | | | | | | | | |
| **Hospitals - CFC** | | | | | | | | | | | | | | | | | | | | |
| General Hospital | 1 | | 1 | 1 | 1 | | | | 1 | | | | 1 | | 1 | 1 | | 1 | 1 | 10 |
| Hospital System | | | | | | | | 1 | | | | | | | | | | | | 1 |

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.
*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.
*Lucas county CFC hospital system must be a hospital system that includes forty-five (45) pediatric beds and ten (10) pediatric intensive care unit (PICU) beds.

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Practitioners - ABD** | | | | | | | | | | | | | | | | | | | | |
| Cardiovascular | | | | | | | | 1 | | | | | | | | | | | 2 | 3 |

## Northwest Region

| | Allen | Auglaize | Defiance | Fulton | Hancock | Hardin | Henry | Lucas | Mercer | Ottawa | Paulding | Putnam | Sandusky | Seneca | Van Wert | Williams | Wood | Wyandot | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dentists | 1 | | | 1 | | | | 6 | | | | 1 | 1 | | | 1 | | | | 11 |
| Gastroenterology | | | | | | | | 1 | | | | | | | | | | | 1 | 2 |
| General Surgeons | 1 | | | | | | | 2 | | | | | | | | | 1 | | 1 | 5 |
| Nephrology | | | | | | | | | | | | | | | | | | | 1 | 1 |
| Neurology | | | | | | | | 1 | | | | | | | | | | | 1 | 2 |
| OB/GYNs | 1 | | | | | | | 2 | | | | | 1 | 1 | | | 1 | | | 6 |
| Oncology | | | | | | | | | | | | | | | | | | | 1 | 1 |
| Orthopedists | 1 | | | | 1 | | | 1 | | | | | | | | | 1 | | | 4 |
| Otolaryngologist | | | | | | | | 1 | | | | | | | | | | | 1 | 2 |
| Physical Med Rehab | | | | | | | | 1 | | | | | | | | | | | 1 | 2 |
| Podiatry | | | | | | | | 2 | | | | | | | | | 1 | | 1 | 4 |
| Psychiatry | 1 | | | | | | | 3 | | | | | | | | | | | 1 | 5 |
| Urology | | | | | | | | 1 | | | | | | | | | | | 1 | 2 |
| Vision | 1 | | 1 | | | | | 2 | 1 | | | | 1 | | 1 | | | | | 7 |

*All required providers and additional required providers must be located within the region.

| **Practitioners - CFC** | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pediatricians | 4 | | | | 1 | | | 23 | | | | | 1 | | | 1 | 2 | | 13 | 45 |
| OB/GYNs | 2 | | | | 1 | | | 5 | | | | | 1 | 1 | | | 1 | | 2 | 13 |
| Vision | 2 | 1 | 1 | | 1 | | | 7 | 1 | | | | 1 | | | 1 | 2 | | 1 | 18 |
| General Surgeons | 2 | | | | 1 | | | 4 | | | | | 1 | | | 1 | 2 | | 2 | 13 |
| Otolaryngologist | 1 | | | | 1 | | | 2 | | | | | | | | | | | 3 | 7 |
| Allergists | 1 | | | | | | | 1 | | | | | | | | | | | 1 | 3 |
| Orthopedists | 2 | | | | 1 | | | 2 | | | | | 1 | | | | 1 | | | 7 |
| Dentists | 4 | 1 | 1 | 1 | 2 | 1 | 1 | 20 | 1 | 1 | | 1 | 2 | 2 | 1 | 1 | 2 | 1 | 2 | 45 |

*All required providers and additional required providers must be located within the region.
*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

## Southwest Region

| | Adams | Brown | Butler | Clermont | Clinton | Hamilton | Highland | Warren | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **PCP Capacity - ABD** | | | | | | | | | | |
| Capacity | 346 | 187 | 1,157 | 507 | 146 | 3,268 | 241 | 238 | | 6,090 |
| PCPs | 3 | 1 | 4 | 3 | 1 | 6 | 2 | 2 | | 22 |
| | | | | | | | | | | |
| **PCP Capacity - CFC** | | | | | | | | | | |
| Capacity | 2,063 | 2,122 | 12,296 | 5,787 | 1,705 | 29,787 | 2,240 | 2,754 | | 58,754 |

*Any additional required CFC capacity must be located within the region.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Hospitals - ABD** | | | | | | | | | | |
| General Hospital | | 1 | 1 | | 1 | 1 | 1 | | 1 | 6 |
| Hospital System | | | | | | 2 | | | | 2 |
| | | | | | | | | | | |
| **Hospitals - CFC** | | | | | | | | | | |
| General Hospital | | 1 | 1 | | 1 | 1 | 1 | | 1 | 6 |
| Hospital System | | | | | | 2 | | | | 2 |

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.
*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.
*Hamilton county CFC general hospital must be a hospital that includes two-hundred (200) pediatric beds and thirty-five (35) pediatric intensive care unit (PICU) beds.
*Grandview OR Miami Valley is the additional required CFC general hospital.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Practitioners - ABD** | | | | | | | | | | |
| Cardiovascular | | | | | | 1 | | 1 | 2 | 4 |

## Southwest Region

| | Adams | Brown | Butler | Clermont | Clinton | Hamilton | Highland | Warren | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Dentists | | | 3 | 1 | | 8 | 1 | 1 | 1 | 15 |
| Gastroenterology | | | | | | | | | 2 | 2 |
| General Surgeons | | | 1 | 1 | 1 | 3 | 2 | 1 | | 9 |
| Nephrology | | | | | | | | | 1 | 1 |
| Neurology | | | | | | | | | 2 | 2 |
| OB/GYNs | | 1 | 1 | | | 4 | | 1 | | 7 |
| Oncology | | | | | | | | | 1 | 1 |
| Orthopedists | | | 1 | | | 2 | | | 2 | 5 |
| Otolaryngologist | | | | | | 1 | | | 1 | 2 |
| Physical Med Rehab | | | | | | | | | 2 | 2 |
| Podiatry | | | 1 | | | 2 | | | 2 | 5 |
| Psychiatry | | | | | | 3 | | | 4 | 7 |
| Urology | | | | | | | | | 3 | 3 |
| Vision | | | 1 | | 1 | 3 | 1 | 1 | 1 | 8 |

*All required providers and additional required providers must be located within the region.

| **Practitioners - CFC** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Pediatricians | | | 7 | 2 | 1 | 39 | | | 10 | 59 |
| OB/GYNs | | 1 | 2 | 1 | 1 | 9 | | 1 | 1 | 16 |
| Vision | | | 3 | 1 | 1 | 11 | 1 | 1 | 3 | 21 |
| General Surgeons | | | 2 | 1 | 1 | 7 | | 1 | 1 | 13 |
| Otolaryngologist | | | 1 | | | 3 | | 1 | 1 | 6 |
| Allergists | | | | | | 4 | | | 3 | 7 |
| Orthopedists | | | 2 | | | 5 | | | 2 | 9 |
| Dentists | 1 | 1 | 10 | 4 | 1 | 26 | 2 | 2 | 3 | 50 |

*All required providers and additional required providers must be located within the region.

*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

## Southeast Region

| | Athens | Belmont | Coshocton | Gallia | Guernsey | Harrison | Jackson | Jefferson | Lawrence | Meigs | Monroe | Morgon | Muskingum | Noble | Vinton | Washington | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PCP Capacity - ABD** | | | | | | | | | | | | | | | | | | |
| Capacity | 536 | 478 | 178 | 334 | 289 | 127 | 340 | 556 | 802 | 273 | 102 | 116 | 633 | 55 | 139 | 353 | | 5,311 |
| PCPs | 2.00 | 2.00 | 1.00 | 2.00 | 2.00 | 1.00 | 2.00 | 3.00 | 4.00 | 2.00 | 1.00 | 1.00 | 3.00 | 1.00 | 1.00 | 2.00 | | 30.00 |
| | | | | | | | | | | | | | | | | | | |
| **PCP Capacity - CFC** | | | | | | | | | | | | | | | | | | |
| Capacity | 2,664 | 3,178 | 1,840 | 1,918 | 2,518 | 810 | 2,107 | 3,418 | 4,021 | 1,557 | 750 | 930 | 5,304 | 581 | 1,061 | 2,755 | 7,000 | 42,412 |

*Any additional required CFC capacity must be located within the region.

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hospitals - ABD** | | | | | | | | | | | | | | | | | | |
| General Hospital | 1 | 1 | 1 | 1 | 1 | | | 1 | | | | | 1 | | | 1 | | 8 |
| Hospital System | | | | | | | | | | | | | | | | | | 0 |
| | | | | | | | | | | | | | | | | | | |
| **Hospitals - CFC** | | | | | | | | | | | | | | | | | | |
| General Hospital | 1 | 1 | 1 | 1 | 1 | | | 1 | | | | | 1 | | | 1 | 3 | 11 |
| Hospital System | | | | | | | | | | | | | | | | | | 0 |

*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.
*Additional CFC general hospitals must include Cabell AND King's Daughter AND Children's Hospital Columbus.

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Practitioners - ABD** | | | | | | | | | | | | | | | | | | |
| Cardiovascular | | | | 1 | | | | | | | | | | | | | 1 | 2 |

## Southeast Region

| | Athens | Belmont | Coshocton | Gallia | Guernsey | Harrison | Jackson | Jefferson | Lawrence | Meigs | Monroe | Morgon | Muskingum | Noble | Vinton | Washington | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dentists | 1 | 1 | | | 1 | | | | 1 | | | | 1 | | | 1 | 2 | 8 |
| Gastroenterology | | | | | | | | | | | | | | | | | 2 | 2 |
| General Surgeons | | 1 | | 1 | 1 | | | 1 | | | | | 1 | | | | | 5 |
| Nephrology | | | | | | | | | | | | | | | | | 1 | 1 |
| Neurology | | | | | | | | | | | | | | | | | 2 | 2 |
| OB/GYNs | 1 | | | | 1 | | | 1 | | | | | 1 | | | 1 | 1 | 6 |
| Oncology | | | | | | | | | | | | | | | | | 1 | 1 |
| Orthopedists | | | | 1 | | | | | | | | | | | | | 3 | 4 |
| Otolaryngologist | | | | 1 | | | | | | | | | 1 | | | | | 2 |
| Physical Med Rehab | | | | | | | | | | | | | | | | | 2 | 2 |
| Podiatry | | 1 | | | | | | | | | | | 1 | | | | 2 | 4 |
| Psychiatry | | 1 | | | | | | | | | | | 1 | | | | 2 | 4 |
| Urology | | | | | | | | | | | | | | | | | 2 | 2 |
| Vision | 1 | 1 | | 1 | 1 | | 1 | | 1 | | | | 1 | | | 1 | | 8 |
| *All required providers and additional required providers must be located within the region. | | | | | | | | | | | | | | | | | | |
| **Practitioners - CFC** | | | | | | | | | | | | | | | | | | |
| Pediatricians | 1 | 1 | | 2 | 1 | | | 1 | | | | | 2 | | | 1 | 22 | 31 |
| OB/GYNs | 1 | | | | 1 | | | 1 | | | | | 1 | | | 1 | 4 | 9 |
| Vision | 1 | 1 | | 1 | 1 | | 1 | 1 | 1 | | | | 2 | | | 1 | 3 | 13 |
| General Surgeons | | 1 | | 1 | 1 | | | 1 | | | | | 1 | | | 1 | 2 | 8 |
| Otolaryngologist | | | | 1 | | | | | | | | | 1 | | | | 1 | 3 |
| Allergists | | | | | | | | | | | | | | | | | 1 | 1 |
| Orthopedists | | | | 1 | | | | | | | | | | | | | 4 | 5 |
| Dentists | 2 | 3 | 1 | 1 | 3 | | 1 | 3 | 2 | | | | 3 | | | 2 | 9 | 30 |

*All required providers and additional required providers must be located within the region.
*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

## West Central Region

| | Champaign | Clark | Darke | Greene | Miami | Montgomery | Preble | Shelby | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **PCP Capacity - ABD** | | | | | | | | | | |
| Capacity | 98 | 690 | 120 | 351 | 215 | 2,557 | 110 | 118 | | 4,259 |
| PCPs | 1.00 | 4.00 | 1.00 | 2.00 | 2.00 | 6.00 | 1.00 | 1.00 | | 18.00 |
| | | | | | | | | | | |
| **PCP Capacity - CFC** | | | | | | | | | | |
| Capacity | 1,472 | 7,225 | 1,476 | 4,347 | 2,550 | 22,751 | 1,541 | 1,422 | | 42,784 |

*Any additional CFC required capacity/FTEs must be located within the region.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Hospitals - ABD** | | | | | | | | | | |
| General Hospital | | 1 | | 1 | 1 | | | | 2 | 5 |
| Hospital System | | | | | | 1 | | | | 1 |
| | | | | | | | | | | |
| **Hospitals - CFC** | | | | | | | | | | |
| General Hospital | | 1 | 1 | 1 | 1 | 1 | | 1 | | 6 |
| Hospital System | | | | | | 1 | | | | 1 |

*ABD hospital systems include: physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

*CFC general hospitals must provide obstetrical services if such a hospital is available in the county/region.

*Montgomery county CFC general hospital must be a hospital that includes seventy-five (75) pediatric beds and ten (10) pediatric intensive care unit (PICU) beds.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Practitioners - ABD** | | | | | | | | | | |

## West Central Region

| | Champaign | Clark | Darke | Greene | Miami | Montgomery | Preble | Shelby | Additional Required: In-Region | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Cardiovascular | | | | | | 1 | | | 2 | 3 |
| Dentists | | 1 | | | | 3 | | | 1 | 5 |
| Gastroenterology | | | | | | | | | 1 | 1 |
| General Surgeons | | 1 | | 1 | | 1 | | | 2 | 5 |
| Nephrology | | | | | | | | | 1 | 1 |
| Neurology | | | | | | | | | 2 | 2 |
| OB/GYNs | | 1 | | 1 | | 3 | | | | 5 |
| Oncology | | | | | | | | | 1 | 1 |
| Orthopedists | | | | 1 | | 1 | | | 1 | 3 |
| Otolaryngologist | | | | | | 1 | | | 1 | 2 |
| Physical Med Rehab | | | | | | | | | 2 | 2 |
| Podiatry | | | | | | 2 | | | 2 | 4 |
| Psychiatry | | | | 1 | | 2 | | | 2 | 5 |
| Urology | | | | | | | | | 2 | 2 |
| Vision | | 1 | | 1 | | 3 | | | 2 | 7 |

*All required providers and additional required providers must be located within the region.

| **Practitioners - CFC** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Pediatricians | | 2 | | 3 | 1 | 22 | | | 8 | 36 |
| OB/GYNs | | 2 | | 1 | 1 | 6 | | 1 | 1 | 12 |
| Vision | | 2 | 1 | 2 | 2 | 10 | | 1 | 2 | 20 |
| General Surgeons | | 2 | | 2 | 1 | 3 | | | 2 | 10 |
| Otolaryngologist | | 1 | | | | 3 | | | 3 | 7 |
| Allergists | | | | | | 2 | | | 2 | 4 |
| Orthopedists | | | | 1 | | 2 | | | 2 | 5 |
| Dentists | 1 | 5 | 1 | 3 | 3 | 20 | | 1 | 4 | 38 |

*All required providers and additional required providers must be located within the region.
*Half of the pediatricians must be certified by the American Board of Pediatrics. No more than two-thirds of this number can be pediatric dentists.

# APPENDIX I

## PROGRAM INTEGRITY

MCPs must comply with all applicable program integrity requirements, including 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 rule 5101:3-26-06, MCPs must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan to guard against fraud and abuse. The MCP'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 MCP will determine the compliance plan's effectiveness.

In addition to the requirements in OAC rule 5101:3-26-06, the MCP'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 MCPs must, as a condition of receiving Medicaid payment, do the following:

i. Establish and make readily available to all employees, including the MCP'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 MCP'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 MCP contractors and agents that provide detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil

or criminal penalties; the laws governing the rights of employees to be protected as whistleblowers; and the MCP's policies and procedures for detecting and preventing fraud, waste, and abuse. MCPs 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 MCP's program which safeguards against fraud and abuse must specifically address the MCP's prevention, detection, investigation, and reporting strategies in at least the following areas:

i. Embezzlement and theft – MCPs must monitor activities on an ongoing basis to prevent and detect activities involving embezzlement and theft (e.g., by staff, providers, contractors, etc.) and respond promptly to such violations.

ii. Underutilization of services – MCPs must monitor for the potential underutilization of services by their members in order to assure that all Medicaid-covered services are being provided, as required. If any underutilized services are identified, the MCP must immediately investigate and, if indicated, correct the problem(s) which resulted in such underutilization of services.

The MCP's monitoring efforts must, at a minimum, include the following activities: a) an annual review of their prior authorization procedures to determine that they do not unreasonably limit a member's access to Medicaid-covered services; b) an annual review of the procedures providers are to follow in appealing the MCP's denial of a prior authorization request to determine that the process does not unreasonably limit a member's access to Medicaid-covered services; and c) ongoing monitoring of MCP service denials and utilization in order to identify services which may be underutilized.

iii. Claims submission and billing – On an ongoing basis, MCPs 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 bundling, to the satisfaction of ODJFS.

c. Reporting MCP fraud and abuse activities: Pursuant to OAC rule 5101:3-26-06, MCPs are required to submit annually to ODJFS a report which summarizes the MCP's fraud and abuse activities for the previous year in each of the areas specified above. The MCP's report must also identify any proposed changes to the MCP's compliance plan for the coming year.

d. Member fraud: MCPs are required to promptly report all suspicions of member fraud to the appropriate County Department of Job and Family Services (CDJFS).

e. Reporting fraud and abuse: MCPs are required to promptly report all instances of provider fraud and abuse to ODJFS and member fraud to the CDJFS. The MCP, at a minimum, must report the following information on cases where the MCP's investigation has revealed that an incident of fraud and/or abuse has occurred:

i. Provider's name and Medicaid provider number or provider reporting number (PRN);

ii. Source of complaint;

iii. Type of provider;

iv. Nature of complaint;

v. Approximate range of dollars involved, if applicable;

vi. Results of MCP's investigation and actions taken;

vii. Name(s) of other agencies/entities (e.g., medical board, law enforcement) notified by MCP; and

viii. Legal and administrative disposition of case, including actions taken by law enforcement officials to whom the case has been referred.

f. Monitoring for prohibited affiliations: The MCP's policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the MCP will not knowingly have a relationship with individuals debarred by Federal Agencies, as specified in Article XII of the Agreement.

g. The MCP must disclose to ODJFS in accordance with 42 CFR 455.104 information on ownership and control including at a minimum:

i. the name and address of each person with an ownership or control interest in the MCP or in any subcontractor in which the MCP has direct or indirect ownership of 5 percent or more;

ii. if any of the persons named is related to another as spouse, parent, child, or sibling;

iii. the name of any other Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent. in which a person with an ownership or control interest in the MCP also has an ownership or control interest.

iv. Updated information must be furnished within 35 days upon request from ODJFS or HHS;

h. In accordance with 42 CFR 455.105, the MCP must submit within 35 days of the date requested by ODJFS or HHS full and complete information about:

i. the ownership of any subcontractor with whom the MCP has had business transactions totaling more than $25, 000 during the 12-month period ending on the date of the request.
ii. any significant business transactions between the MCP and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

i. The MCP must disclose the following information on persons convicted of crimes in accordance with 42 CFR 455.106:

   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.

j. In accordance with 42 CFR 1002.3(b), MCPs must notify ODJFS when the MCPs deny credentialing to providers for program integrity reasons.

k. Non-federally qualified MCPs must report to ODJFS a description of certain transactions with parties of interest as outlined in section 1903(m)(4)(A) of SSA [42 U.S.C. 1396b].

2. <u>Data Certification:</u>
   Pursuant to 42 CFR 438.604 and 42 CFR 438.606, MCPs are required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to ODJFS which may affect MCP payment.

a. <u>MCP Submissions:</u> MCPs must submit the appropriate ODJFS-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. Case Management Data [as specified in the Data Quality Appendix (Appendix L)]

b. Source of Certification: The above MCP data submissions must be certified by one of the following:

i. The MCP's Chief Executive Officer;

ii. The MCP's Chief Financial Officer, or

iii. An individual who has delegated authority to sign for, or who reports directly to, the MCP's Chief Executive Officer or Chief Financial Officer.

ODJFS may also require MCPs to certify as to the accuracy, completeness, and truthfulness of additional submissions.

**MCP:**

# APPENDIX J

# FINANCIAL PERFORMANCE

## 1. SUBMISSION OF FINANCIAL STATEMENTS AND REPORTS

MCPs must submit the following financial reports to ODJFS:

a. The National Association of Insurance Commissioners (NAIC) quarterly and annual Health Statements (hereafter referred to as the "Financial Statements"), as outlined in OAC rule 5101:3-26-09(B). The Financial Statements must include all required Health Statement filings, schedules and exhibits as stated in the NAIC Annual Health Statement Instructions including, but not limited to, the following sections: Assets, Liabilities, Capital and Surplus Account, Cash Flow, Analysis of Operations by Lines of Business, Five-Year Historical Data, and the Exhibit of Premiums, Enrollment and Utilization. The Financial Statements must be submitted to the Bureau of Managed Care (BMC) even if the ODI does not require the MCP to submit these statements to ODI. A signed hard copy and an electronic copy of the reports in the NAIC-approved format must both be provided to ODJFS;

b. Hard copies of annual financial statements for those entities who have an ownership interest totaling five percent or more in the MCP or an indirect interest of five percent or more, or a combination of direct and indirect interest equal to five percent or more in the MCP;

c. Annual audited Financial Statements prepared by a licensed independent external auditor as submitted to the ODI, as outlined in OAC rule 5101:3-26-09(B);

d. Medicaid MCP Annual ODJFS Cost Reports for both the ABD and CFC programs and the auditor's certification of the cost report, as outlined in OAC rule 5101:3-26-09(B);

e. Medicaid MCP Annual Restated Cost Report for both the ABD and CFC programs for the prior calendar year. The restated cost report shall be audited upon the BMC's request;

f. Annual physician incentive plan disclosure statements and disclosure of and changes to the MCP's physician incentive plans, as outlined in OAC rule 5101:3-26-09(B);

g. Reinsurance agreements, as outlined in OAC rule 5101:3-26-09(C);

h. Prompt Pay Reports, in accordance with OAC rule 5101:3-26-09(B). A hard copy and an electronic copy of the reports in the ODJFS-specified format must be provided to ODJFS;

i. Notification of requests for information and copies of information released pursuant to a tort action (i.e., third party recovery), as outlined in OAC rule 5101:3-26-09.1;

j. Financial, utilization, and statistical reports, when ODJFS requests such reports, based on a concern regarding the MCP's quality of care, delivery of services, fiscal operations or solvency, in accordance with OAC rule 5101:3-26-06(D);

k. MCPs must submit ODJFS-specified reports for the calculation of items 2b. and 2c. below in hard copy and electronic formats.

*Penalty for noncompliance:* Noncompliance with submission of the above items will result in penalties, as outlined in Appendix N of the Provider Agreement.

## 2. FINANCIAL PERFORMANCE MEASURES AND STANDARDS

This Appendix establishes specific expectations concerning the financial performance of MCPs. In the interest of administrative simplicity and non-duplication of areas of the ODI authority, ODJFS' emphasis is on the assurance of access to and quality of care. ODJFS will focus only on a limited number of indicators and related standards to monitor plan performance. The three indicators and standards for this contract period are identified below, along with the calculation methodologies. The source for each indicator will be the NAIC Quarterly and Annual Financial Statements. The report period that will be used to determine compliance will be the annual Financial Statement.

a. **Indicator**: **Net Worth as measured by Net Worth Per Member**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Net Worth Per Member indicator.

*Standard*: For the period of July, 2009 through June, 2010, a minimum net worth per member of $_____, was determined from the annual CY 2008 Financial Statement submitted to ODI and the ODJFS.

b. **Indicator:** **Administrative Expense Ratio**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Administration Expense Ratio indicator.

*Standard:* Administrative Expense Ratio not to exceed 15%, as determined from the annual Financial Statement submitted to ODI and ODJFS.

c. **Indicator:** **Overall Expense Ratio**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Overall Expense Ratio indicator.

*Standard:* Overall Expense Ratio not to exceed 100% as determined from the annual Financial Statement submitted to ODI and ODJFS.

*Penalty for noncompliance:* Noncompliance with the above standards will result in penalties, as outlined in Appendix N of the Provider Agreement.

In addition, ODJFS will review two liquidity indicators if a plan demonstrates potential problems in meeting related administrative requirements or the standards listed above. The two standards, 2.d and 2.e, reflect ODJFS' expected level of performance. At this time, ODJFS has not established penalties for noncompliance with these standards; however, ODJFS will consider the MCP's performance regarding the liquidity measures, in addition to indicators 2.a., 2.b., and 2.c., in determining whether to impose a new enrollment freeze, as outlined above, or to not issue or renew a contract with an MCP. The source for each indicator will be the NAIC Quarterly and annual Financial Statements.

Long-term investments that can be liquidated without significant penalty within 24 hours, which a plan would like to include in cash and short-term investments in the next two measurements, must be disclosed in footnotes on the NAIC Reports. Descriptions and amounts should be disclosed. Please note that "significant penalty" for this purpose is any penalty greater than 20%. Also, enter the amortized cost of the investment, the market value of the investment, and the amount of the penalty.

d. **Indicator**: **Days Cash on Hand**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Days Cash on Hand liquidity measure.

*Standard*: Greater than 25 days as determined from the annual Financial Statement submitted to ODI and ODJFS.

e. **Indicator**: **Ratio of Cash to Claims Payable**

Please refer to the ODJFS Methods for Financial Performance Measures for the definition and calculations for the Ratio of Cash to Claims Payable liquidity measure.

*Standard*: Greater than 0.83 as determined from the annual Financial Statement submitted to ODI and ODJFS.

## 3. REINSURANCE REQUIREMENTS

Pursuant to the provisions of OAC rule 5101:3-26-09(C), each MCP must carry reinsurance coverage from a licensed commercial carrier to protect against inpatient-related medical expenses incurred by Medicaid members.

The annual deductible or retention amount for such insurance must be specified in the reinsurance agreement and must not exceed $75,000.00, except as provided below. Except for transplant services, and as provided below, this reinsurance must cover, at a minimum, 80% of inpatient costs incurred by one member in one year, in excess of $75,000.00.

For transplant services, the reinsurance must cover, at a minimum, 50% of inpatient transplant related costs incurred by one member in one year, in excess of $75,000.00.

An MCP may request a higher deductible amount and/or that the reinsurance cover less than 80% of inpatient costs in excess of the deductible amount. If the MCP does not have more than 75,000 members in Ohio, but does have more than 75,000 members between Ohio and other states, ODJFS may consider alternate reinsurance arrangements. However, depending on the corporate structures of the Medicaid MCP, other forms of security may be required in addition to reinsurance. These other security tools may include parental guarantees, letters of credit, or performance bonds. In determining whether or not the request will be approved, the ODJFS may consider any or all of the following:

a. Whether the MCP has sufficient reserves available to pay unexpected claims;

b. The MCP's history in complying with financial indicators 2.a., 2.b., and 2.c., as specified in this Appendix;

c. The number of members covered by the MCP;

d. How long the MCP has been covering Medicaid or other members on a full risk basis;

e. Risk based capital ratio greater than 2.5 or higher calculated from the last annual ODI financial statement.;

f. Scatter diagram or bar graph from the last calendar year that shows the number of reinsurance claims that exceeded the current reinsurance deductible graph/chart showing the claims history for reinsurance above the previously approved deductible from the last calendar year.

For the ABD population, the MCP has been approved to have a reinsurance policy with a deductible amount of $_____ that covers 80% of inpatient costs in excess of the deductible amount for non-transplant services.

For the CFC population, the MCP has been approved to have a reinsurance policy with a deductible amount of $_____ that covers 80% of inpatient costs in excess of the deductible amount for non-transplant services.

*Penalty for noncompliance:* Noncompliance with submission of the above items will result in penalties, as outlined in Appendix N of the Provider Agreement.

## 4. PROMPT PAY REQUIREMENTS

In accordance with 42 CFR 447.46, MCPs must pay 90% of all submitted clean claims within 30 days of the date of receipt and 99% of such claims within 90 days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule that is mutually agreed upon and described in their contract. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the MCP and delegated claims processing entities.

The date of receipt is the date the MCP receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or date of electronic payment transmission. A claim means a bill from a provider for health care services that is assigned a unique identifier. A claim does not include an encounter form.

A "claim" can include any of the following: (1) a bill for services; (2) a line item of services; or (3) all services for one recipient within a bill. A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

Clean claims do not include payments made to a provider of service or a third party where the timing of the payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

*Penalty for noncompliance:* Noncompliance with submission of the above items will result in penalties, as outlined in Appendix N of the Provider Agreement.

## 5. PHYSICIAN INCENTIVE PLAN DISCLOSURE REQUIREMENTS

MCPs must comply with the physician incentive plan requirements stipulated in 42 CFR 438.6(h)**.** If the MCP operates a physician incentive plan, no specific payment can be made directly or indirectly under this physician incentive plan to a physician or physician

group as an inducement to reduce or limit medically necessary services furnished to an individual.

If the physician incentive plan places a physician or physician group at substantial financial risk [as determined under paragraph (d) of 42 CFR 422.208] for services that the physician or physician group does not furnish itself, the MCP must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with paragraph (f) of 42 CFR 422.208, and conduct periodic surveys in accordance with paragraph (h) of 42 CFR 422.208.

In accordance with 42 CFR 417.479 and 42 CFR 422.210, MCPs must maintain copies of the following required documentation and submit to ODJFS upon request:

a. A description of the types of physician incentive arrangements the MCP has in place which indicates whether they involve a withhold, bonus, capitation, or other arrangement. If a physician incentive arrangement involves a withhold or bonus, the percent of the withhold or bonus must be specified.

b. A description of information/data feedback to a physician/group on their: 1) adherence to evidence-based practice guidelines; and 2) positive and/or negative care variances from standard clinical pathways that may impact outcomes or costs. The feedback information may be used by the MCP for activities such as physician performance improvement projects that include incentive programs or the development of quality improvement initiatives.

c. A description of the panel size for each physician incentive plan. If patients are pooled, then the pooling method used to determine if substantial financial risk exists must also be specified.

d. If more than 25% of the total potential payment of a physician/group is at risk for referral services, the MCP must maintain a copy of the results of the required patient satisfaction survey and documentation verifying that the physician or physician group has adequate stop-loss protection, including the type of coverage (e.g., per member per year, aggregate), the threshold amounts, and any coinsurance required for amounts over the threshold.

Upon request by a member or a potential member and no later than 14 calendar days after the request, the MCP must provide the following information to the member: (1) whether the MCP uses a physician incentive plan that affects the use of referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of the survey results if the MCP was required to conduct a survey. The information provided by the MCP must adequately address the member's request.

## 6. NOTIFICATION OF REGULATORY ACTION

Any MCP notified by the ODI of proposed or implemented regulatory action must report such notification and the nature of the action to ODJFS no later than one working day after receipt from ODI. The ODJFS may request, and the MCP must provide, any additional information as necessary to assure continued satisfaction of program requirements. MCPs may request that information related to such actions be considered proprietary in accordance with established ODJFS procedures. Failure to comply with this provision will result in an immediate enrollment freeze.

# APPENDIX K

# QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM AND EXTERNAL QUALITY REVIEW

## 1. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

As required by federal regulation, 42 CFR 438.240, each managed care plan (MCP) must have an ongoing Quality Assessment and Performance Improvement Program (QAPI) that is annually prior-approved by the Ohio Department of Job and Family Services (ODJFS). The program must include the following elements:

### a. PERFORMANCE IMPROVEMENT PROJECTS

Each MCP must conduct performance improvement projects (PIPs), including those specified by ODJFS. PIPs must achieve, through periodic measurements and intervention, significant and sustained improvement in clinical and non-clinical areas which are expected to have a favorable effect on health outcomes and satisfaction. MCPs must adhere to ODJFS PIP content and format specifications.

All ODJFS-specified PIPs must be prior-approved by ODJFS. In addition, the MCP must annually submit to ODJFS the status and results of each PIP. The external quality review organization (EQRO) will assist MCPs with conducting PIPs by providing technical assistance, and will annually validate the PIPs. As a result of the EQRO validation process, the MCP must implement specific actions based on pre-established performance levels as outlined in the *Standards for Performance Improvement Project Accountability*. Failure to meet any performance requirement will result in sanctions and remedial actions per Appendix N.

The MCPs will be required to participate in a PIP collaborative beginning in SFY 2009, and as specified by ODJFS. A PIP Collaborative is defined as a cooperative quality improvement effort by the MCP, ODJFS, and the EQRO to address a clinical or non-clinical topic area relevant to the Medicaid managed care program, which is designed to identify, develop, and implement standardized measures and statewide interventions to optimize health outcomes for MCP members and improve efficiencies related to health care service delivery.

MCPs serving CFC members must initiate and complete the following PIPs:

i. Non-Clinical Topic: Identifying members with special health care needs.
ii. Clinical Topic: Percentage of members aged 2 to 21 years that access dental services.
iii. PIP Collaborative Clinical Topic: Increasing access to Early Periodic Screening Diagnosis and Treatment (EPSDT) services for members aged 0 to 21 years.

MCPs serving CFC and/or ABD members must initiate and complete the following PIP:

i. Clinical Topic: Increasing access to comprehensive diabetes services for members aged 18 – 75 years with diabetes.

Initiation of the PIPs will begin in the second year of participation in the Medicaid managed care program.

b. HEALTH CARE SERVICE UTILIZATION

Each MCP must have mechanisms in place to detect under- and over-utilization of health care services. The MCP must specify the mechanisms used to monitor utilization in its annual submission of the QAPI program to ODJFS.

It should also be noted that pursuant to the program integrity provisions outlined in Appendix I, MCPs must monitor for the potential under-utilization of services by their members in order to assure that all Medicaid-covered services are being provided, as required. If any under-utilized services are identified, the MCP must immediately investigate and correct the problem(s) which resulted in such under-utilization of services.

In addition the MCP must conduct an ongoing review of service denials and must monitor utilization on an ongoing basis in order to identify services which may be under-utilized.

c. SPECIAL HEALTH CARE NEEDS

Each MCP must have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. The MCP must specify the mechanisms used in its annual submission of the QAPI program to ODJFS.

d. SUBMISSION OF PERFORMANCE MEASUREMENT DATA

Each MCP must submit data as required by ODJFS that enables ODJFS to calculate standard measures as defined in Appendix M.

Each MCP must also submit self-reported, audited HEDIS data (see *ODJFS Methodology for MCP Self-Reported, HEDIS-Audited Data*) for performance measures set forth in Appendix M.

e. QAPI PROGRAM SUBMISSION

Each MCP must implement an evaluation process to review, revise, and/or update the QAPI program. The MCP must annually submit its QAPI program for review and approval by ODJFS.

## 2. EXTERNAL QUALITY REVIEW

In addition to the following requirements, MCPs must participate in external quality review activities as outlined in OAC 5101:3-26-07.

a. EQRO ADMINISTRATIVE REVIEWS

The EQRO will conduct annual focused administrative compliance assessments for each MCP which will include, but not be limited to, the following domains as specified by ODJFS: member rights and services, QAPI program, care management, provider networks, grievance system, coordination and continuity of care, and utilization management. In addition, the EQRO will complete a comprehensive administrative compliance assessment every three (3) years as required by 42 CFR 438.358 and specified by ODJFS.

In accordance with 42 CFR 438.360 and 438.362, MCPs with accreditation from a national accrediting organization approved by the CMS may request a non-duplication exemption from certain specified components of the administrative review. ODJFS will inform the MCPs when a non-duplication exemption may be requested.

b. EXTERNAL QUALITY REVIEW PERFORMANCE

In accordance with OAC rule 5101:3-26-07, each MCP must participate in an annual external quality review survey. If the EQRO cites a deficiency in performance, the MCP will be required to complete a Corrective Action Plan (CAP) (e.g., ODJFS technical assistance session) or Quality Improvement Directives (QIDs) depending on the severity of the deficiency. An example of a deficiency is if an MCP fails to meet certain clinical or administrative standards as supported by national evidence-based guidelines or best practices. Serious deficiencies may result in immediate termination or non-renewal of the provider agreement. These quality improvement measures recognize the importance of ongoing MCP performance improvement related to clinical care and service delivery.

the provider agreement. These quality improvement measures recognize the importance of ongoing MCP performance improvement related to clinical care and service delivery.

# APPENDIX L

# DATA QUALITY

A high level of performance on the data quality measures established in this appendix is crucial in order for the ODJFS to determine the value of the ABD and CFC Medicaid Managed Health Care programs and to evaluate Medicaid consumers' access to and quality of services. Data collected from MCPs 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 incentives. The data will also be used in conjunction with the cost reports in setting the premium payment rates. Data sets collected from MCPs with data quality standards include: encounter data; care management data; data used in the external quality review; members' PCP data; and appeal and grievance data.

The following measures, as specified in this appendix, will be calculated per MCP and include all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable): Incomplete Outpatient Hospital Data, Rejected Encounters, Acceptance Rate, Encounter Data Accuracy Study measure 2 (Payment Accuracy), and Generic Provider Number Usage. The Encounter Data Volume measure and IDSS Data Quality Reconciliation measure will be calculated separately for each program (i.e., ABD and CFC) an MCP serves. The Incomplete Data for Last Menstrual Period measure and the Encounter Data Accuracy Study measure 1 (Delivery Encounters) will be calculated for the CFC program only.

ODJFS 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 and/or upon the implementation of MITS. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's performance level for that contract period.

## 1. ENCOUNTER DATA

The encounter data measures set forth in this appendix will be revised upon implementation of MITS.

For detailed descriptions of the encounter data quality measures below, see *ODJFS Methods for the CFC and ABD Encounter Data Quality Measures*.

### 1.a. Encounter Data Completeness

Each MCP's encounter data submissions will be assessed for completeness. The MCP is responsible for collecting information from providers and reporting the data to ODJFS in accordance with program requirements established in Appendix C, *MCP Responsibilities*. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with other performance standards.

**1.a.i. Encounter Data Volume**

This measure is calculated separately for each program (i.e., ABD and CFC) an MCP serves.

*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). The measure will be calculated per MCP separately for each program (i.e., ABD and CFC).

*Report Period*: The report periods for the SFY 2011 and SFY 2012 contract periods are listed in Table 1 below. Note: The pharmacy service category is reporting only beginning with report period Q1 2010.

**Table 1. Report Periods for the SFY 2011 and SFY 2012 Contract Periods**

| CFC Quarterly Report Periods | ABD Quarterly Report Periods | Data Source: Estimated Encounter Data File Update | Quarterly Report Estimated Issue Date | Contract Period |
|---|---|---|---|---|
| Qtr 2 thru Qtr 4: 2007, Qtr 1 thru Qtr 4: 2008, 2009 Qtr 1 2010 | Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009, Qtr 1 2010 | July 2010 | August 2010 | SFY 2011 |
| Qtr 3, Qtr 4: 2007, Qtr 1 thru Qtr 4: 2008, 2009 Qtr 1, Qtr 2: 2010 | Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009, Qtr 1, Qtr 2 2010 | October 2010 | November 2010 | |
| Qtr 4: 2007, Qtr 1 thru Qtr 4: 2008, 2009 Qtr 1 thru Qtr 3: 2010 | Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009, Qtr 1 thru Qtr 3 2010 | January 2011 | February 2011 | |
| Qtr 1 thru Qtr 4: 2008, 2009, 2010 | Qtr 1 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009, Qtr 1 thru Qtr 4 2010 | April 2011 | May 2011 | |
| Qtr 2 thru Qtr 4: 2008, Qtr 1 thru Qtr 4: 2009, 2010 Qtr 1 2011 | Qtr 2 thru Qtr 4 2008, Qtr 1 thru Qtr 4 2009, 2010 Qtr 1 2011 | July 2011 | August 2011 | SFY 2012 |
| Qtr 3, Qtr 4: 2008, Qtr 1 thru Qtr 4: 2009, 2010 Qtr 1, Qtr 2: 2011 | Qtr 3, Qtr 4: 2008, Qtr 1 thru Qtr 4: 2009, 2010 Qtr 1, Qtr 2: 2011 | October 2011 | November 2011 | |
| Qtr 4: 2008, Qtr 1 thru Qtr 4: 2009, 2010 Qtr 1 thru Qtr 3: 2011 | Qtr 4: 2008, Qtr 1 thru Qtr 4: 2009, 2010 Qtr 1 thru Qtr 3: 2011 | January 2012 | February 2012 | |
| Qtr 1 thru Qtr 4: 2009, 2010, 2011 | Qtr 1 thru Qtr 4: 2009, 2010, 2011 | April 2012 | May 2012 | |

Qtr1 = January to March; Qtr2 = April to June; Qtr3 = July to September; Qtr 4 = October to December

**ABD Statewide Interim Approach**

ODJFS will evaluate MCP performance using the ABD statewide interim standards for encounter data volume for dates of service through June 30, 2009. The quarterly report issued in November, 2009 for dates of service through June 30, 2009 will be the last evaluation using the ABD statewide interim standards.

*Interim Data Quality Standard:* The utilization rate for all service categories listed in Table 2 below must be equal to or greater than the interim standards established in Table 2.

**Table 2. ABD Statewide Interim Standards – Encounter Data Volume**

| Category | Measure per 1,000/MM | Standard for Dates of Service from 1/1/2007 Thru 6/30/2009 | Description |
|---|---|---|---|
| Inpatient Hospital | Discharges | 2.7 | General/acute care, excluding newborns and mental health and chemical dependency services |
| Emergency Department | Visits | 25.3 | Includes physician and hospital emergency department encounters |
| Dental | | 25.5 | Non-institutional and hospital dental visits |
| Vision | | 5.3 | Non-institutional and hospital outpatient optometry and ophthalmology visits |
| Primary and Specialist Care | | 116.6 | Physician/practitioner and hospital outpatient visits |
| Ancillary Services | | 66.8 | Ancillary visits |
| Behavioral Health | Service | 5.2 | Inpatient and outpatient behavioral encounters |
| Pharmacy* | Prescriptions | 246.1 | Prescribed drugs |

*For reports issued on and after August 2010: MCPs will be held accountable for this measure in the pharmacy service category for report periods prior to Q1 2010. Report periods Q1 2010 and thereafter will be reporting only for the pharmacy service category.

**ABD Statewide Approach**

Transition to the statewide approach will occur for dates of service beginning July 1, 2009. The first evaluation using the ABD statewide standards was issued in March, 2010. Encounter data volume will be evaluated by MCP, statewide (i.e., one utilization rate per service category for all regions in the state).

*Data Quality Standard:* The utilization rate for all service categories listed in Table 3 below must be equal to or greater than the standards established in Table 3.

**Table 3. ABD Statewide Standards – Encounter Data Volume**

| Category | Measure per 1,000/MM | Standard for Dates of Service on or after July 1, 2009 | Description |
|---|---|---|---|
| Inpatient Hospital | Discharges | 22.0 | General/acute care, excluding newborns and mental health and chemical dependency services |
| Emergency Department | Visits | 135.0 | Includes physician and hospital emergency department encounters |
| Dental | | 28.1 | Non-institutional and hospital dental visits |
| Vision | | 19.2 | Non-institutional and hospital outpatient optometry and ophthalmology visits |
| Primary and Specialist Care | | 452.0 | Physician/practitioner and hospital outpatient visits |
| Ancillary Services | | 589.1 | Ancillary visits |
| Behavioral Health | Service | 75.5 | Inpatient and outpatient behavioral encounters |
| Pharmacy* | Prescriptions | 4260.4 | Prescribed drugs |

*For reports issued on and after August 2010: MCPs will be held accountable for this measure in the pharmacy service category for report periods prior to Q1 2010. Report periods Q1 2010 and thereafter will be reporting only for the pharmacy service category.

## CFC Interim Statewide Approach

Prior to the transition to the statewide approach, encounter data volume will be evaluated by MCP, using a CFC interim statewide approach. All regions with managed care membership will be included in results for an interim statewide encounter data volume measure until statewide evaluation is implemented (see Statewide Approach below). Encounter data volume will be evaluated by MCP. The utilization rate for all service categories listed in Table 4 must be equal to or greater than the standard established in Table 4 below. The standards listed in Table 4 below are based on utilization data for counties with managed care membership as of February 1, 2006, and have been adjusted to accommodate estimated differences in utilization for all counties in a region, including counties that did not have membership as of February 1, 2006.

Prior to implementation of the CFC statewide approach, an MCP's encounter data volume will be evaluated using and the CFC interim statewide approach.

*Data Quality Standard, Interim Statewide Approach*: The standards in Table 4 below apply to the MCP's CFC interim statewide results. The utilization rate for all service categories listed in Table 4 must be equal to or greater than the standard established in Table 4.

**Table 4. CFC Interim Statewide Standards – Encounter Data Volume**

| Category | Measure per 1,000/MM | Standard for Dates of Service from 7/1/2006 thru 6/30/2009 | Description |
|---|---|---|---|
| Inpatient Hospital | Discharges | 2.7 | General/acute care, excluding newborns and mental health and chemical dependency services |
| Emergency Department | Visits | 25.3 | Includes physician and hospital emergency department encounters |
| Dental | | 25.5 | Non-institutional and hospital dental visits |
| Vision | | 5.3 | Non-institutional and hospital outpatient optometry and ophthalmology visits |
| Primary and Specialist Care | | 116.6 | Physician/practitioner and hospital outpatient visits |
| Ancillary Services | | 66.8 | Ancillary visits |
| Behavioral Health | Service | 5.2 | Inpatient and outpatient behavioral encounters |
| Pharmacy* | Prescriptions | 246.1 | Prescribed drugs |

*For reports issued on and after August 2010: MCPs will be held accountable for this measure in the pharmacy service category for report periods prior to Q1 2010. Report periods Q1 2010 and thereafter will be reporting only for the pharmacy service category.

## CFC Statewide Approach

Transition to the CFC statewide approach will occur for dates of service beginning July 1, 2009. The first evaluation using the CFC statewide standards was issued in March, 2010. Encounter data volume will be evaluated by MCP, statewide (i.e., one utilization rate per service category for all regions in the state).

*Data Quality Standard, Statewide Approach*:
The standards in Table 5 below apply to the MCP's CFC statewide results. The standards listed in Table 5 are based on utilization data for regions and have been adjusted to accommodate estimated differences in utilization for all counties in a region, including counties that did not have membership as of February 1, 2006. The utilization rate for all service categories listed in Table 5 must be equal to or greater than the standard established in Table 5.

**Table 5. CFC Statewide Standards for Dates of Service on or after July 1, 2009 – Encounter Data Volume**

| Category | Measure per 1,000/MM | Standard for Dates of Service on or after July 1, 2009 | Description |
|---|---|---|---|
| Inpatient Hospital | Discharges | 4.6 | General/acute care, excluding newborns and mental health and chemical dependency services |
| Emergency Department | Visits | 61.6 | Includes physician and hospital emergency department encounters |
| Dental | | 34.0 | Non-institutional and hospital dental visits |
| Vision | | 11.6 | Non-institutional and hospital outpatient optometry and ophthalmology visits |
| Primary and Specialist Care | | 267.5 | Physician/practitioner and hospital outpatient visits |
| Ancillary Services | | 152.5 | Ancillary visits |
| Behavioral Health | Service | 16.0 | Inpatient and outpatient behavioral encounters |
| Pharmacy* | Prescriptions | 579.9 | Prescribed drugs |

*For reports issued on and after August 2010: MCPs will be held accountable for this measure in the pharmacy service category for report periods prior to Q1 2010. Report periods Q1 2010 and thereafter will be reporting only for the pharmacy service category.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standards for this measure.

### 1.a.ii. Incomplete Outpatient Hospital Data

This measure is calculated per MCP and includes all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable).

Since July 1, 1997, MCPs have been required to provide both the revenue code and the HCPCS code on applicable outpatient hospital encounters. ODJFS will be monitoring, on a quarterly basis, the percentage of hospital encounters which contain a revenue code and CPT/HCPCS code. A CPT/HCPCS code must accompany certain revenue center codes. These codes are listed in Appendix B of OAC rule 5101:3-2-21 (FFS outpatient hospital policies) and in the methods for calculating the completeness measures.

*Measure:* The percentage of outpatient hospital line items with certain revenue center codes, as explained above, which had an accompanying valid procedure (CPT/HCPCS) code. The measure will be calculated per MCP for all programs an MCP serves.

*Report Period*: For the report periods for the SFY 2011 and SFY 2012 contract periods, performance will be evaluated using the report periods are listed in Table 6 below.

**Table 6. Report Periods for the SFY 2011 and SFY 2012 Contract Periods**

| Combined CFC and ABD Quarterly Report Periods | Data Source: Estimated Encounter Data File Update | Quarterly Report Estimated Issue Date | Contract Period |
|---|---|---|---|
| Qtr 2 thru Qtr 4: 2007,<br>Qtr 1 thru Qtr 4: 2008, 2009<br>Qtr 1 2010 | July 2010 | August 2010 | SFY 2011 |
| Qtr 3, Qtr 4: 2007,<br>Qtr 1 thru Qtr 4: 2008, 2009<br>Qtr 1, Qtr 2: 2010 | October 2010 | November 2010 | |
| Qtr 4: 2007,<br>Qtr 1 thru Qtr 4: 2008, 2009<br>Qtr 1 thru Qtr 3: 2010 | January 2011 | February 2011 | |
| Qtr 1 thru Qtr 4: 2008, 2009, 2010 | April 2011 | May 2011 | |
| Qtr 2 thru Qtr 4: 2008,<br>Qtr 1 thru Qtr 4: 2009, 2010<br>Qtr 1 2011 | July 2011 | August 2011 | SFY 2012 |
| Qtr 3, Qtr 4: 2008,<br>Qtr 1 thru Qtr 4: 2009, 2010<br>Qtr 1, Qtr 2: 2011 | October 2011 | November 2011 | |
| Qtr 4: 2008,<br>Qtr 1 thru Qtr 4: 2009, 2010<br>Qtr 1 thru Qtr 3: 2011 | January 2012 | February 2012 | |
| Qtr 1 thru Qtr 4: 2009, 2010, 2011 | April 2012 | May 2012 | |

Qtr 1 = January-March; Qtr 2 = April-June; Qtr 3 = July-September; Qtr 4 = October-December

*Data Quality Standard*: The data quality standard is a minimum rate of 95%.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standard for this measure.

### 1.a.iii. CFC - Incomplete Data For Last Menstrual Period

This measure is calculated for the CFC program only.

As outlined in *ODJFS Encounter Data Specifications*, the last menstrual period (LMP) field is a required encounter data field. It is discussed in Item 14 of the "HCFA 1500 Billing Instructions." The date of the LMP is essential for calculating the clinical performance measures and allows the ODJFS to adjust performance expectations for the length of a pregnancy.

The occurrence code and date fields on the UB-92, which are "optional" fields, can also be used to submit the date of the LMP. These fields are described in Items 32a & b, 33a & b, 34a & b, 35a & b of the "Inpatient Hospital" and "Outpatient Hospital UB-92 Claim Form Instructions."

An occurrence code value of '10' indicates that a LMP date was provided. The actual date of the LMP would be given in the 'Occurrence Date' field.

*Measure:* The percentage of recipients with a live birth during the report period where a "valid" LMP date was given on one or more of the recipient's perinatal claims. If the LMP date is before the date of birth and there is a difference of between 119 and 315 days between the date the recipient gave birth and the LMP date, then the LMP date will be considered a valid date. The measure will be calculated per MCP (i.e., to include the MCP's service area for the CFC.

*Report Period*: For the SFY 2011 contract period, performance will be evaluated using the January - December 2010 report period. For the SFY 2012 contract period, performance will be evaluated using the January - December 2011 report period.

*Data Quality Standard*: The data quality standard is a minimum rate of 80%.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standard for this measure.

**1.a.iv. Rejected Encounters**

Encounters submitted to ODJFS that are incomplete or inaccurate are rejected and reported back to the MCPs on the Exception Report. If an MCP does not resubmit rejected encounters, ODJFS' encounter data set will be incomplete.

These measures are calculated per MCP and include all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable).

**1) Measure 1 - Measure 1 only applies to MCPs that have had Medicaid membership for more than one year.** Note: Effective with the January - March, 2010 report period, the NCPDP file type was excluded from this measure.

*Measure 1:* The percentage of encounters submitted to ODJFS that are rejected. The measure will be calculated per MCP.

*Report Period*: For the SFY 2011 contract period, performance will be evaluated using the following report periods: July - September 2010; October - December 2010; January - March 2011; and April – June 2011. For the SFY 2012 contract period, performance will be evaluated using the following report periods: July - September 2011; October - December 2011; January - March 2012; and April – June 2012.

*Data Quality Standard for measure 1:* The data quality standard for measure 1 is a maximum encounter data rejection rate of 10% for each file type in the ODJFS-specified medium per format. The measure will be calculated per MCP.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standard for this measure.

**2) Measure 2 - Measure 2 only applies to MCPs that have had Medicaid membership for one year or less.** Note: Effective with the March, 2010 report period, the NCPDP file type was excluded from this measure.

*Measure 2:* The percentage of encounters submitted to ODJFS that are rejected. The measure will be calculated per MCP.

*Report Period*: 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 ODJFS-specified medium per format as follows:

Third through sixth month with membership: 50%

Seventh through twelfth month with membership: 25%

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with the standard for this measure.

**1.a.v. Acceptance Rate**

This measure is calculated per MCP and includes all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable).

**This measure only applies to MCPs that have had Medicaid membership for one year or less.**

*Measure:* The rate of encounters that are submitted to ODJFS and accepted (i.e. accepted encounters per 1,000 member months). The measure will be calculated per MCP.

*Report Period*: The report 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 ODJFS-specified medium per format as follows:

Third through sixth month with membership:
50 encounters per 1,000 MM for NCPDP (discontinued effective March, 2010)
65 encounters per 1,000 MM for NSF
20 encounters per 1,000 MM for UB-92

Seventh through twelfth month of membership:
250 encounters per 1,000 MM for NCPDP (discontinued effective March, 2010)
350 encounters per 1,000 MM for NSF
100 encounters per 1,000 MM for UB-92

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, MCPs are responsible for assuring the collection and submission of accurate data to ODJFS. Failure to do so jeopardizes MCPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

**1.b.i. Encounter Data Accuracy Studies**

***Measure 1 (CFC program only):*** The focus of this accuracy study will be on delivery encounters. Its primary purpose will be to verify that MCPs submit encounter data accurately and to ensure only one payment is made per delivery. The rate of appropriate payments will be determined by comparing a sample of delivery payments to the medical record. The measure will be calculated per MCP for MCPs serving the CFC program (i.e., to include the MCP's entire service area for the CFC membership).

*Report Period*: In order to provide timely feedback on the accuracy rate of encounters, the report period will be the most recent from when the measure is initiated. This measure is conducted annually.

Medical records retrieval from the provider and submittal to ODJFS or its designee is an integral component of the validation process. ODJFS has optimized the sampling to minimize the number of records required. This methodology requires a high record submittal rate. To aid MCPs in achieving a high submittal rate, ODJFS will give at least an 8 week period to retrieve and submit medical records as a part of the validation process. A record submittal rate will be calculated as a percentage of all records requested for the study.

*Data Quality Standard 1 for Measure 1*: For results that are finalized during the contract year, the accuracy rate for encounters generating delivery payments is 100%.

*Data Quality Standard 2 for Measure 1*: A minimum record submittal rate of 85%.

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with the standards for this measure.

***Measure 2 (CFC and ABD combined, if applicable):*** This accuracy study will compare the accuracy and completeness of payment data stored in MCPs' claims systems during the study period to payment data submitted to and accepted by ODJFS. The measure will be calculated per MCP. 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, institutional, and pharmacy) and stratifying data by file type (i.e., header and detail). Effective SFY 2011, the pharmacy claim type will not be included in this study.

Encounter Data Completeness (Level 1):
Omission Encounter Rate: The percentage of encounters in an MCP's fully adjudicated claims file not present in the ODJFS encounter data files.

Surplus Encounter Rate: The percentage of encounters in the ODJFS encounter data files not present in an MCP's fully adjudicated claims files.

Payment Data Accuracy (Level 2):
Payment Error Rate: The percentage of matched encounters between the ODJFS encounter data files and an MCP'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 biennially.

*Data Quality Standard for Measure 2 (Note - This is determined by a biennial study):*

For SFY 2012:
For Level 1: An omission encounter rate and a surplus encounter rate of no more than 11% for both header and detail records.
For Level 2: A payment error rate of no more than 4%.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standard for this measure.

**1.b.ii. Generic Provider Number Usage**

This measure is calculated per MCP and includes all Ohio Medicaid members receiving services from the MCP (i.e., ABD and CFC membership, if applicable).

*Measure:* This measure is the percentage of institutional (UB-92) and professional (NSF) encounters with the generic provider number in the Medicaid Provider Number field. Providers submitting claims which do not have a Medicaid Management Information System (MMIS) provider number in the Medicaid Provider Number field must be submitted to ODJFS with the generic provider number (i.e. 9111115). The measure will be calculated per MCP. The report period for this measure is quarterly.

*Report Period*: For the SFY 2011 and SFY 2012 contract periods, performance will be evaluated using the CFC quarterly report periods listed in 1.a.i., Table 1.

*Data Quality Standard:* A maximum generic provider number usage rate of 10%.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standard for this measure.

**1.c. Timely Submission of Encounter Data**

**1.c.i. Timeliness**

ODJFS recommends submitting encounters no later than thirty-five days after the end of the month in which they were paid. ODJFS does not monitor standards specifically for timeliness, but the minimum claims volume (Section 1.a.i.) and the rejected encounter (Section 1.a.iv.) standards are based on encounters being submitted within this time frame.

**1.c.ii. Submission of Encounter Data Files in the ODJFS-Specified Medium per Format**

Information concerning the proper submission of encounter data may be obtained from the *ODJFS Encounter Data File Submission Specifications* document. The MCP must submit a letter of certification, using the form required by ODJFS, with each encounter data file in the ODJFS-specified medium per format.

The letter of certification must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO.

**2. MCP SELF-REPORTED, AUDITED HEDIS DATA**

**2.a. Annual Submission of IDSS Data**

MCPs are required to collect, report, and submit to ODJFS self-reported, audited *Healthcare Effectiveness Data and Information Set* (HEDIS) data (see *ODJFS Methodology for MCP Self-Reported, Audited HEDIS Results*) for the performance measures set forth in Appendix M. The self-reported, audited HEDIS data are due to ODJFS no later than five business days after the NCQA due date.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this data submission requirement.

**2.b. Annual Submission of Final HEDIS Audit Report (FAR)**

MCPs are required to submit their FAR that contains the audited results for Ohio's Medicaid HEDIS production process to ODJFS no later than five business days after the NCQA due date (see *ODJFS Methodology for MCP Self-Reported, Audited HEDIS Results*).

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this data submission requirement.

Note: ODJFS will review each MCP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODJFS will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. ODJFS reserves the right to pursue corrective action based on this review (see Appendix N, Section K.).

**2.c. IDSS Data Submission and Audit Report Procedures**

In accordance with 42 CFR 438.600, each MCP must submit a signed data certification letter to ODJFS attesting to the accuracy and completeness of its audited HEDIS IDSS data submitted to ODJFS. Each MCP must also submit to ODJFS a signed data certification letter attesting to the accuracy and completeness of its final HEDIS audit report (FAR) submitted to ODJFS.

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

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with these data submission requirements.

**2.d. IDSS Data Quality Reconciliation Measure**

For a detailed description of this measure, see *ODJFS Methodology for IDSS Data Quality Measure*.

This measure is calculated separately for each program (i.e., ABD and CFC) an MCP serves.

This measure is intended to provide information regarding the MCP's encounter data quality through an evaluation of rate deviations observed between the MCP's IDSS administrative rate (derived from HEDIS IDSS) and ODJFS calculated administrative rate (per the *ODJFS Methods for Clinical Performance Measures for the CFC Population, ODJFS Methods for Clinical Performance Measures for the ABD Population, ODJFS Methods for Access Performance Measures for the CFC Population*, and *ODJFS Methods for Access Performance Measures for the ABD Population*.)

*ABD / CFC Measure*: The number of measures exceeding the discrepancy rate, OR any given measure exceeding a pre-established threshold. (A discrepancy rate and threshold rate for each measure is TBD.)

*Report Period*: Performance will be evaluated annually. For the SFY 2011 contract period, a baseline level of performance will be set using CY 2010 data. (SFY 2011 is reporting only.) For the SFY 2012 contract period, the report period is CY 2011. SFY 2012 is the first year that MCPs will be held accountable to the data quality standard for this measure.

*Data Quality Standard:* TBD in October 2011

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the data quality standard for this measure.

## 3. CARE MANAGEMENT DATA

ODJFS designed a Care Management System (CAMS) in order to monitor MCP compliance with program requirements specified in Appendix G, *Coverage and Services*. Each MCP's care management data submissions will be assessed for completeness and accuracy. The MCP is responsible for submitting a care management file every month according to the specifications established in *ODJFS' Care Management File and Submission Specifications*. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with care management requirements.

### 3.a. Timely Submission of Care Management Files

*Data Quality Submission Requirement*: The MCP must submit Care Management files on a monthly basis according to the specifications established in *ODJFS' Care Management Files and Submission Specifications.*

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with this requirement.

## 4. MEMBERS' PCP DATA

The designated PCP is the provider who will manage and coordinate the overall care for members, including those who have care management needs. The MCP must submit a Members' Designated PCP file every month. Specialists may and should be identified as the PCP as appropriate for the member's condition per the specialty types specified for the ABD and CFC populations in *ODJFS Member's PCP Data File and Submission Specifications*; however, no member may have more than one PCP identified for a given month.

### 4.a. Timely submission of Members' PCP Data

*Data Quality Submission Requirement:* The MCP must submit a Members' Designated PCP Data file on a monthly basis according to the specifications established in *ODJFS Member's PCP Data File and Submission Specifications*.

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with this requirement.

## 5. APPEALS AND GRIEVANCES DATA

Pursuant to OAC rule 5101:3-26-08.4, MCPs are required to submit appeal and grievance activity to ODJFS as directed. ODJFS 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 G*rievance 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 ODJFS-specified due date. These data files must be submitted in the ODJFS-specified format and with the ODJFS-specified filename in order to be successfully processed.

MCPs who fail to submit their monthly electronic data files to the ODJFS 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 penalty as stipulated under the Compliance Assessment System (Appendix N).

## 6. UTILIZATION MANAGEMENT DATA

Pursuant to OAC rule 5101:3-26-03.1, MCPs are required to submit information on prior authorization requests as directed by ODJFS. Effective January 2011, ODJFS 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.

quality requirements will be subject to penalty as stipulated under the Compliance Assessment System (Appendix N).

## 6. UTILIZATION MANAGEMENT DATA

Pursuant to OAC rule 5101:3-26-03.1, MCPs are required to submit prior authorization request information to ODJFS, as directed. Effective January 1, 2011, ODJFS requires information on denied prior authorization requests to be submitted weekly in an electronic data file format pursuant to the *Utilization Management Tracking Database: Prior Authorization File and Submission Specifications*. The electronic data on denied prior authorization requests shall include the service types and information from state hearing forms issued to the members by the MCP (e.g., member identifying information, date of decision, service requested, basis for denial etc.).

# APPENDIX M

## PERFORMANCE EVALUATION

This appendix establishes performance measures and Minimum Performance Standards for managed care plans (MCPs) in key program areas, under the Agreement. The intent is to maintain accountability for contract requirements. Performance measures and standards are subject to change based on the revision or update of applicable national measures, standards, methods, benchmarks, or other factors as deemed relevant. Performance will be evaluated in the categories of Quality of Care, Access, Consumer Satisfaction, and Administrative Capacity. Most performance measures have an accompanying Minimum Performance Standard. MCPs with performance levels below the Minimum Performance Standards will be required to take corrective action. Selected measures in this appendix will be used to determine incentives as specified in Appendix O, *Pay for Performance (P4P).*

All performance measures, as specified in this appendix, are calculated per MCP. All performance measures in this appendix are calculated separately for each program an MCP serves (i.e., Aged, Blind, or Disabled (ABD), Covered Families and Children (CFC)), with one exception. The Independent External Quality Review measure may or may not include all Ohio members receiving services from the MCP (i.e., ABD and CFC, as applicable) depending on the clinical and non-clinical areas of performance under review in any given year. An MCP's performance is evaluated utilizing statewide results that include all members who meet the criteria specified per the given methodology for each measure.

The Ohio Department of Job and Family Services (ODJFS) reserves the right to revise report periods (and corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's performance level for that contract period.

Effective February 1, 2010, the pharmacy benefit was carved out of the Medicaid Managed Care Program. The impact of this policy change on certain measures in this Appendix is not yet known. Therefore, notwithstanding the penalties listed in Appendix N, *Compliance Assessment System*, ODJFS reserves the right to apply the most appropriate penalty and/or to adjust performance measure results with respect to the Appendix M measures and for the associated time periods listed below.

**SFY 2010:** Care Management of High Risk Members (*CFC, ABD*); Consumer Satisfaction *(CFC, ABD)*; **SFY 2011:** Care Management of Members (*CFC, ABD*); Care Management of High Risk Members (*CFC, ABD*); Inpatient Hospital Discharge Rate *(ABD)*; Emergency Department Utilization Rate *(ABD)*; Inpatient Hospital Readmission Rate *(ABD)*; Coronary Artery Disease – Persistence of Beta Blocker Treatment after Heart Attack *(ABD)*; Comprehensive Diabetes Care/Eye Exam (*ABD*); Asthma - Use of Appropriate Medications for People with Asthma *(CFC, ABD)*; and Emergency Department Diversion *(CFC, ABD)*.

ODJFS is introducing two new performance measures, effective SFY 2011, to monitor MCP utilization management of pharmaceuticals, as specified in Section 4.c. of this Appendix.

Effective SFY 2012, ODJFS will use an MCP's self-reported, audited *Healthcare Effectiveness Data and Information Set* (HEDIS) data to assess plan performance on specific measures used for performance evaluation, as set forth in this Appendix, and used to determine performance incentives, as set forth in Appendix O, *Pay-for-Performance*.

Effective SFY 2011, MCPs will be required to submit self-reported, audited HEDIS data to ODJFS for specific performance measures (see *MCP Self-Reported, Audited HEDIS Results Methodology*), as set forth in this appendix. Data submitted in SFY 2011 (CY 2010 data) will be used as a baseline to set a standard for SFY 2012 (CY 2011 data). In subsequent years, the self-reported, audited HEDIS data will be compared to NCQA Audit Means, Percentiles and Ratios released in the prior Spring to determine performance evaluation for HEDIS measures (e.g., the CY 2010 self-reported, audited HEDIS results submitted in Summer [approx. July] 2011 will be compared to the HEDIS benchmarks released in Spring [approx. April] 2010). SFY 2012 will be the first year that MCPs will be held accountable to the standards established for these (HEDIS) measures.

Effective SFY 2012, based on its review of an MCP's final HEDIS audit report (FAR) and any "Not Report" (i.e., NR) audit designations assigned, ODJFS reserves the right to not use the MCP's self-reported, audited HEDIS data to evaluate the MCP's performance on one or more HEDIS performance measures and/or to pursue corrective action (such as requiring the MCP to implement a corrective action plan) per Appendix N, Section K.

## 1. QUALITY OF CARE

### 1.a. Independent External Quality Review

In accordance with federal law and regulations, state Medicaid agencies must annually provide for an external quality review of the quality outcomes and timeliness of, and access to, services provided by Medicaid-contracting MCPs [(42 CFR 438.204(d)]. The external review assists the state in assuring MCP compliance with program requirements and facilitates the collection of accurate and reliable information concerning MCP performance.

*Measure:* The independent external quality review covers a review of clinical and non-clinical performance as outlined in Appendix K.

*Report Period:* Performance will be evaluated using the reviews conducted during SFY 2011.

The penalties for noncompliance with this measure are listed in Appendix N, *Compliance Assessment System.*

**1.b. Members with Special Health Care Needs (MSHCN)**

In order to ensure state compliance with the provisions of 42 CFR 438.208, the Bureau of Policy and Health Plan Services (BPHPS) established care management basic program requirements as set forth in Appendix G, *Coverage and Services* of the Agreement, and corresponding performance measures and Minimum Performance Standards as described below. The purpose of these measures is to ensure appropriate care management services are provided to MSHCN who have specific diagnoses and/or who require high-cost or extensive services. For detailed methodologies for each measure, see *ODJFS Methods for Members with Special Healthcare Needs Performance Measures for the ABD Program*, and *ODJFS Methods for Members with Special Healthcare Needs Performance Measures for the CFC Program.*

**1.b.i.** *ABD / CFC* **Care Management of Members** *(applicable to performance evaluation beginning January 2009)*

ABD / CFC *Measure:* The average monthly care management rate for members who have had at least three consecutive months of enrollment in one MCP (including members assigned to low, medium, and high risk stratification levels).

*ABD / CFC Report Period:* For the SFY 2010 contract period, July-December 2009 (baseline – reporting only), and January – June 2010. For the SFY 2011 contract period, July – December 2010, and January – June 2011 report periods. For the SFY 2012 contract period, July – December 2011, and January – June 2012 report periods.

*ABD / CFC Regional-Based Statewide Approach:* MCPs are evaluated using a regional-based statewide result, including all regions in which an MCP has membership.

*ABD / CFC Regional-Based Statewide Target:* For SFY 2010, SFY 2011, and SFY 2012, the target is a care management rate of 70% for the ABD population and 15% for the CFC population.

*ABD / CFC Regional-Based Statewide Minimum Performance Level:* For SFY 2010, SFY 2011, and SFY 2012, a care management rate of 27.0% for the ABD population and 5.0% for the CFC population.

*ABD / CFC Regional-Based Statewide Minimum Performance Standard:* For SFY 2010, SFY 2011, and SFY 2012, for the MCP that falls below the minimum performance level, the MCP must meet the minimum performance level. For the MCP that already meets the minimum performance level, the MCP must achieve a level of improvement that is at least a 5.0% decrease in the difference between the target and the previous report period's results.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

**1.b.ii.** *ABD / CFC* **Care Management of High Risk Members** *(applicable to performance evaluation beginning January 2009 and P4P beginning SFY 2009)*

*ABD / CFC Measure:* The percent of high risk members who have had at least three consecutive months of enrollment in one MCP that are care managed.

*ABD / CFC Report Period:* For the SFY 2010 contract period, July – September 2009, October – December 2009, January – March 2010, and April – June 2010 report periods. For the SFY 2011 contract period, July – September 2010, October – December 2010, January – March 2011, and April – June 2011 report periods. For the SFY 2012 contract period, July – September 2011, October – December 2011, January – March 2012, and April – June 2012 report periods.

*ABD / CFC Regional-Based Statewide Approach:* Performance is evaluated using a regional-based statewide approach for all active regions in which the MCP has membership.

*ABD / CFC Regional-Based Statewide Target:* For SFY 2010, SFY 2011, and SFY 2012, the target is a care management rate of 80% for the ABD population and 70% for the CFC population.

*ABD / CFC Minimum Performance Standard:* For SFY 2010, SFY 2011, and SFY 2012, the standard is a level of improvement that is at least a 5.0% decrease in the difference between the target and the previous report period's results.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

This measure is included in the P4P Incentive System, as established in Appendix O, *Pay-for-Performance (P4P).*

**1.c. Clinical Performance Measures**

MCP performance will be assessed based on the analysis of ODJFS calculated performance measurement data or self-reported, audited HEDIS data for each measure, as described below. For certain measures, standards are established; the identification of these standards is not intended to limit the assessment of other indicators for performance improvement activities. Performance on multiple measures will be assessed and reported to the MCPs and others, including Medicaid consumers.

**ODFJS Calculated Clinical Performance Measures**

(*Note: ODJFS calculated performance measurement data will continue to be used to evaluate* ***all*** *clinical performance measures through SFY 2011. Effective SFY 2012, ODJFS calculated performance measurement data will no longer be used to evaluate the CFC clinical performance measures. ODJFS calculated performance measurement data will continue to be used to evaluate some, but not all, of the ABD clinical performance measures, as specified in Section 1.c.ii. below.)*

The ODJFS calculated clinical performance measures described below closely follow the National Committee for Quality Assurance's (NCQA's) HEDIS measures. Minor adjustments to HEDIS measures are required to account for the differences between the commercial population and Medicaid population, such as shorter and interrupted enrollment periods. NCQA may annually change its method for calculating a measure. These changes can make it difficult to evaluate whether improvement occurred from a prior year. For this reason, ODJFS will use the same methods to calculate the baseline results and the results for the period in which the MCP is being held accountable. For example, the same methods are used to calculate calendar year 2008 results (the baseline period) and calendar year 2009 results. The methods will be updated and a new baseline will be created during 2009 for calendar year 2010 results. These results will then serve as the baseline to evaluate whether improvement occurred from calendar year 2009 to calendar year 2010. Clinical performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims runout.

**MCP Self-Reported, Audited HEDIS Data**

(*Note: Effective SFY 2012, ODJFS will use an MCP's self-reported, audited HEDIS data to evaluate all of the CFC clinical performance measures and some, but not all, of the ABD clinical performance measures, as specified in Section 1.c.ii. below.)*

Effective SFY 2011, each MCP is required to annually submit self-reported, audited HEDIS data using NCQA's Interactive Data Submission System (IDSS) per *ODJFS Methodology for MCP Self-Reported, Audited HEDIS Results*. Effective SFY 2012, ODJFS will use an MCP's self-reported, audited HEDIS data to assess plan performance on the HEDIS clinical performance measures.

The self-reported, audited HEDIS data submitted in SFY 2011 (CY 2010 data) will be used as a baseline to set a standard for SFY 2012 (CY 2011 data). In subsequent years, the self-reported, audited HEDIS data will be compared to NCQA Audit Means, Percentiles and Ratios released in the prior Spring to determine performance evaluation for HEDIS measures (e.g., the CY 2010 self-reported, audited HEDIS results submitted in Summer [approx. July] 2011 will be compared to the HEDIS benchmarks released in the Spring [approx. April] 2010). SFY 2012 will be the first year that MCPs will be held accountable to the standards established for HEDIS measures.

**1.c.i. Approach**

*ABD / CFC Regional-Based Statewide Approach:* MCPs are evaluated using a regional-based statewide result, including all regions in which an MCP has membership.

*ABD / CFC Report Period:* For the SFY 2010 contract period, performance will be evaluated using the January – December 2009 report period. For the SFY 2011 contract period, performance will be evaluated using the January – December 2010 report period. For the SFY 2012 contract period, performance will be evaluated using the January – December 2011 report period.

For a comprehensive description of the ODJFS calculated clinical performance measures below, see *ODJFS Methods for Clinical Performance Measures for the ABD Program*, and *ODJFS Methods for Clinical Performance Measures for the CFC Program*. For a comprehensive description of the MCP self-reported, audited HEDIS measures below, see *ODJFS Methodology for MCP Self-Reported, Audited HEDIS Results*. Performance measures and standards are subject to change, based on the revision or update of NCQA methods or other national measures, standards, methods or benchmarks.

**1.c.ii. Measures, Targets, and Standards**

**<u>ABD Program</u>**

MCPs serving the ABD population are held accountable for their performance on the measures listed in Table 1 below.

MCPs will be evaluated using the targets and Minimum Performance Standards listed in Table 1 below. For HEDIS measures, MCP self-reported, audited HEDIS data submitted in SFY 2011 (CY 2010 data) will be used as a baseline to set targets and Minimum Performance Standards for SFY 2012 (CY 2011 data).

The penalties for noncompliance with the Minimum Performance Standards for these measures are listed in Appendix N, *Compliance Assessment System*.

**Table 1. Clinical Performance Measures for the ABD Program**

| *Measure* | *Description* | *SFY 2010 and SFY 2011 Target* | *SFY 2010 and SFY 2011 Minimum Performance Standard* | *SFY 2012 Target* | *SFY 2012 Min. Perf. Std.* | *MCP Self-Reported Audited HEDIS Measure Effective SFY 2012* |
|---|---|---|---|---|---|---|
| Inpatient Hospital Discharge Rate* | The number of acute inpatient hospital discharges in the reporting year (where the principal diagnosis was Congestive Health Failure [CHF], Coronary Artery Disease [CAD], Hypertension, Diabetes, | 10.8 discharges per 1,000 member months | The level of improvement must result in at least a 10% decrease in the difference | TBD in October, 2011 | TBD in October, 2011 | No |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Chronic Obstructive Pulmonary Disease [COPD], Asthma, Mental Health [SMD], or Substance Abuse [AOD]), per thousand member months, for members who had the same diagnosis in the year prior to the reporting year. For AOD, members need to have had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: one AOD-related acute inpatient admission or two AOD related emergency department visits. | | between the target and the previous report period's results. | | | |
| Emergency Department (ED) Utilization Rate | The number of emergency department visits in the reporting year (where the primary diagnosis was CHF, CAD, Hypertension, Diabetes, COPD, Asthma, Mental Health [SMD], or Substance Abuse [AOD]), per thousand member months, for members who had the same diagnosis in the year prior to the reporting year. For AOD, members need to have had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: one AOD-related acute inpatient admission or two AOD related emergency department visits. | 14.7 visits per 1,000 member months | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 | No |
| Inpatient Hospital Readmission Rate | The number of CHF, CAD, Mental Health [SMD], or Substance Abuse [AOD] related inpatient hospital readmissions in the reporting year for members who had the same diagnosis in the year prior to the reporting year. A readmission is defined as an admission that occurs within 30 days of a prior admission for the same diagnosis. For AOD, members need to have had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: one AOD-related acute inpatient admission or two AOD related emergency department visits. | 5.9% | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 | No |
| Coronary Artery Disease (CAD) – Persistence of Beta Blocker Treatment after Heart Attack* | The percentage of members 35 years of age and older as of December 31st of the reporting year who were hospitalized and discharged alive from July 1 of the year prior to the reporting year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge. | 82.1% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 | Yes |
| CAD – Cholesterol Management for Patients | The percentage of members who had a diagnosis of CAD in the year prior to the reporting year, who were enrolled for at least 11 months in the | 86.3% (NCQA HEDIS | The level of improvement must result in at least a 10% | TBD in October, 2011 | TBD in October, 2011 | Yes |

| | | | | | | |
|---|---|---|---|---|---|---|
| with Cardiovascular Conditions/LDL-C Screening Performed* | reporting year, and who received a lipid profile during the reporting year. | 2008, 90th Percentile) | decrease in the difference between the target and the previous report period's results. | | | |
| Diabetes – Eye Exam* | The percentage of diabetic members who were enrolled for at least 11 months during the reporting year, and who received one or more retinal or dilated eye exams from an ophthalmologist or optometrist during the reporting year. | 67.6% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | | | Yes |
| Asthma – Use of Appropriate Medications for People with Asthma* | The percentage of members with persistent asthma who received prescribed medications acceptable as primary therapy for long-term control of asthma. | 91.9% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 | Yes |
| Follow-up After Hospitalization for Mental Illness* | The percentage of discharges for members enrolled from the date of discharge through 30 days after discharge, who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit (i.e., were seen on an outpatient basis or were in intermediate treatment with a mental health provider) within:<br>1) 30 Days of discharge, and<br>2) 7 Days of discharge.* | 1)80.3%<br>2)65.4%<br>(NCQA HEDIS 2008, 90th Percentile) | *For each measure*: The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 | Yes |

*This measure is included in the P4P Incentive System, as established in Appendix O, *Pay-for-Performance (P4P)*.

## Informational Only Measures for the ABD Program

The clinical performance measures listed in Table 2 below are informational only. Although there are no performance targets or Minimum Performance Standards for these measures, results will be reported and used as one component in assessing the quality of care provided by MCPs to the ABD managed care population.

**Table 2. Informational Only Measures for the ABD Program**

| Condition | Informational Performance Measure | *MCP Self-Reported, Audited HEDIS Measure Effective SFY 2012* |
|---|---|---|
| **CHF** | Inpatient Hospital Discharge rate | |
| | Emergency Department Utilization Rate | |
| | Inpatient Hospital Readmission Rate | |
| **CAD** | Inpatient Hospital Discharge rate | |
| | Emergency Department Utilization Rate | |
| | Inpatient Hospital Readmission Rate | |
| **Hypertension** | Inpatient Hospital Discharge rate | |
| | Emergency Department Utilization Rate | |
| **Diabetes** | Inpatient Hospital Discharge rate | |
| | Emergency Department Utilization Rate | |
| | Comprehensive Diabetes Care (CDC)/HbA1c testing | Yes |
| | CDC/kidney disease monitored | Yes |
| | CDC/LDL-C screening performed | Yes |
| **COPD** | Inpatient Hospital Discharge rate | |
| | Emergency Department Utilization Rate | |
| | Use of Spirometry Testing in the Assessment and Diagnosis of COPD | Yes |
| **Asthma** | Inpatient Hospital Discharge rate | |
| | Emergency Department Utilization Rate | |
| **Mental Health (SMD)** | Inpatient Hospital Discharge rate | |
| | Emergency Department Utilization Rate | |
| | Inpatient Hospital Readmission Rate | |
| | Antidepressant Medication Management | Yes |
| **Substance Abuse (AOD)** | Inpatient Hospital Discharge rate | |
| | Emergency Department Utilization Rate | |
| | Inpatient Hospital Readmission Rate | |
| | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | Yes |

## CFC Program

MCPs serving the CFC population are held accountable for their performance on the measures listed in Table 3 below.

MCPs serving the CFC population will be evaluated using the regional-based statewide targets and Minimum Performance Standards listed in Table 3 below. MCP self-reported, audited HEDIS date submitted in SFY 2011 (CY 2010 data) will be used as a baseline to set targets and Minimum Performance Standards for SFY 2012 (CY 2011 data). Note, all of the measures in Table 3. below are HEDIS performance measures effective SFY 2012. Note that ODJFS also reports the following HEDIS measures as informational only for the CFC population: Comprehensive Diabetes Care; Emergency Department Use for Asthmatics; Low Birth Weight; and Cesarean Section Rate.

The penalties for noncompliance with the Regional-Based Statewide Minimum Performance Standards for these measures are listed in Appendix N, *Compliance Assessment System*.

**Table 3. Clinical Performance Measures for the CFC Program**

| ***Measure*** | ***Description*** | ***SFY 2010 and SFY 2011 Regional-Based Statewide Target*** | ***SFY 2010 and SFY 2011 Regional-Based Statewide Minimum Perf. Std.*** | ***SFY 2012 Regional-Based Statewide Target*** | ***SFY 2012 Regional-Based Statewide Minimum Perf. Std.*** |
|---|---|---|---|---|---|
| Perinatal Care-Frequency of Ongoing Prenatal Care* | The percentage of enrolled women with a live birth during the year who received the expected number of prenatal visits. The number of observed versus expected visits will be adjusted for length of enrollment. | 80.7% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 |
| Perinatal Care - Timeliness of Prenatal Care* | The percentage of enrolled women with a live birth during the year who had a prenatal visit within 42 days of enrollment or by the end of the first trimester for those women who enrolled in the MCP during the early stages of pregnancy. | 91.4% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 |
| Perinatal Care - Postpartum Care* | The percentage of women who delivered a live birth who had a postpartum visit on or between 21 days and 56 days after delivery. | 70.6% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 |
| Well-Child Visits (two measures)* | The percentage of children who received the expected number of well-child visits adjusted by age and enrollment. The expected number of visits are as follows: 1) Children who turn 15 months old: six or more well-child visits; 2) Children who were 3, 4, 5, or 6, years old: one or more well-child visits; | 1)73.7% 2)78.9% | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 |
| Adolescent Well-Care Visits* | The percentage of children 12 through 21 years of age who received one or more well-care visits. | 56.7% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the | TBD in October, 2011 | TBD in October, 2011 |

| | | | | | |
|---|---|---|---|---|---|
| | | | previous report period's results. | | |
| Use of Appropriate Medications for People with Asthma * | The percentage of members with persistent asthma who were enrolled for at least 11 months with the plan during the year and who received prescribed medications acceptable as primary therapy for long-term control of asthma. | 91.9% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 |
| Annual Dental Visits* | The percentage of enrolled members age 4 through 21 (for SFY2010) age 2 through 21 (for SFY 2011 and 2012) who were enrolled for at least 11 months with the plan during the year and who had at least one dental visit during the year. | 61.3% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 |
| Lead Screening in Children* | The percentage of children who have turned two years of age during the reporting year who have received one lead test on or before their second birthday. | 84.0% (NCQA HEDIS 2008, 90th Percentile) | The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results. | TBD in October, 2011 | TBD in October, 2011 |

*This measure is included in the P4P Incentive System, as established in Appendix O, *Pay-for-Performance (P4P).*

## 2. ACCESS

Performance in the Access category will be determined by the following measures: Children's Access to Primary Care (CFC program only), Adults' Access to Preventive/Ambulatory Health Services, and Adults' Access to Designated PCP. For a comprehensive description of the access performance measures below, see *ODJFS Methods for Access Performance Measures for the ABD Program*, and *ODJFS Methods for Access Performance Measures for the CFC Program*.

### 2.a. CFC Children's Access to Primary Care *(applicable to performance evaluation and P4P through SFY 2010 for the CFC program only)*

This measure indicates whether children aged 12 months to 11 years are accessing PCPs for sick or well-child visits.

*CFC Measure*: The percentage of members age 12 months to 11 years who had a visit with an MCP PCP-type provider.

*CFC Report Period:* For the SFY 2010 contract period, performance will be evaluated using the January – December 2009 report period.

*For any MCP which did not have membership as of February 1, 2006:* Performance will be evaluated using a regional-based statewide approach for all active regions in which the MCP has membership.

*CFC Regional-Based Statewide Approach:* MCPs will be evaluated statewide, using results for all active regions in which the MCP has membership. Statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims run out.

*CFC Regional-Based Statewide Minimum Performance Standards:*
CY 2009 report period – 84%

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

This measure is included in the P4P Incentive System, as established in Appendix O, *Pay-for-Performance (P4P).*

**2.a.i. CFC Children's Access to Primary Care** *(applicable to performance evaluation and P4P as of SFY 2011 for the CFC program only)*

(*Note: ODJFS calculated results will continue to be used for the evaluation of this measure through SFY 2011. Effective SFY 2012, an MCP's self-reported, audited HEDIS data will be used to evaluate plan performance on this measure.*

*Effective SFY 2011, each MCP is required to annually submit self-reported, audited HEDIS data to ODJFS per ODJFS Methodology for MCP Self-Reported, Audited HEDIS Results. The self-reported, audited HEDIS data submitted in SFY 2011 (CY 2010 data) will be used as a baseline to set a standard for SFY 2012 (CY 2011 data) for this measure. In subsequent years, the self-reported, audited HEDIS data will be compared to NCQA Audit Means, Percentiles and Ratios released in the prior Spring to determine performance evaluation for this measure (e.g., the CY 2010 self-reported, audited HEDIS results submitted in Summer [approx. July] 2011 will be compared to the HEDIS benchmarks released in Spring [approx. April] 2010). SFY 2012 will be the first year that MCPs will be held accountable to the standard established for this measure.)*

This measure indicates whether children aged 12 months to 19 years are accessing PCPs for sick or well-child visits.

*CFC Measure*: The percentage of members age 12 months to 19 years who had a visit with an MCP PCP-type provider.

*CFC Report Period:* For the SFY 2011 contract period, performance will be evaluated using the January - December 2010 report period. For the SFY 2012 contract period, performance will be evaluated using the January - December 2011 report period.

*CFC Regional-Based Statewide Approach:* MCPs will be evaluated statewide, using results for all active regions in which the MCP has membership. Through SFY 2011, statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims run out.

*CFC Regional-Based Statewide Minimum Performance Standard:*
CY 2010 report period – 79%
CY 2011 report period – To be determined (in October, 2011).

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

This measure is included in the P4P Incentive System, as established in Appendix O, *Pay-for-Performance (P4P).*

**2.b. ABD Member²s'/CFC Adults' Access to Preventive/Ambulatory Health Services**

(*Note: ODJFS calculated results will continue to be used for the evaluation of this measure through SFY 2011. Effective SFY 2012, an MCP's self-reported, audited HEDIS data will be used to evaluate plan performance on this measure.*

*Effective SFY 2011, each MCP is required to annually submit self-reported, audited HEDIS data to ODJFS per ODJFS Methodology for MCP Self-Reported, Audited HEDIS Results. The self-reported, audited HEDIS data submitted in SFY 2011 (CY 2010 data) will be used as a baseline to set a standard for SFY 2012 (CY 2011 data) for this measure. In subsequent years, the self-reported, audited HEDIS data will be compared to NCQA Audit Means, Percentiles and Ratios released in the prior Spring to determine performance evaluation for this measure (e.g., the CY 2010 self-reported, audited HEDIS results submitted in Summer [approx. July] 2011 will be compared to the HEDIS benchmarks released in Spring [approx. April] 2010). SFY 2012 will be the first year that MCPs will be held accountable to the standard established for this measure.)*

This measure indicates whether ABD members and CFC adult members are accessing health services.

*ABD / CFC Measure*: For the ABD program, this measure is the percentage of members who had an ambulatory or preventive care visit. For the CFC program, this measure is the percentage of members age 20 and older who had an ambulatory or preventive care visit.

*ABD / CFC Report Period:* For the SFY 2010 contract period, performance will be evaluated using the January - December 2009 report period. For the SFY 2011 contract period, performance will be evaluated using the January - December 2010 report period. For the SFY 2012 contract period, performance will be evaluated using the January - December 2011 report period.

*ABD / CFC Regional-Based Statewide Approach*: MCPs will be evaluated statewide using results for all regions in which the MCP has membership. Through SFY 2011, statewide performance

measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims run out.

*ABD / CFC Regional-Based Statewide Minimum Performance Standard*:
CY 2009, CY 2010, and CY 2011 report periods –
For the CFC Program, 75% of adults must receive a visit.
For the ABD Program, 78% of members must receive a visit.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

This measure is included in the P4P Incentive System, as established in Appendix O, *Pay-for-Performance (P4P).*

**3. CONSUMER SATISFACTION**

In accordance with federal requirements and in the interest of assessing enrollee satisfaction with MCP performance, ODJFS conducts an annual independent consumer satisfaction survey. Results are used to assist in identifying and correcting MCP performance overall and in the areas of access to care, quality of care, and member services. The results of this measure are reported annually. For a comprehensive description of the consumer satisfaction performance measure, see *ODJFS Methods for the Consumer Satisfaction Performance Measure for the CFC Program* and *ODJFS Methods for the Consumer Satisfaction Performance Measure for the ABD Program.*

*ABD / CFC Measure:*

This measure is the overall average rating of the respondents to the consumer satisfaction survey who were asked to rate how often they were satisfied with their MCPs' customer service.

*ABD / CFC Report Period:* For the SFY 2010 contract period, performance will be evaluated using the results from the CY 2010 consumer satisfaction survey. For the SFY 2011 contract period, performance will be evaluated using the results from the CY 2011 consumer satisfaction survey. For the SFY 2012 contract period, performance will be evaluated using the results from the CY 2012 consumer satisfaction survey.

*ABD / CFC Regional-Based Statewide Approach*: MCPs will be evaluated annually using a statewide result, including all regions in which an MCP has membership.

*ABD / CFC Regional-Based Statewide Minimum Performance Standard:*

CY 2010, CY 2011, and CY 2012 report periods –
For the ABD Program: an overall average score of no less than 2.0.
For the CFC Program: an overall average score of no less than 2.0.

The penalties for noncompliance with the standards for this measure are listed in Appendix N, *Compliance Assessment System.*

This measure is included in the P4P Incentive System, as established in Appendix O, *Pay-for-Performance (P4P).*

## 4. ADMINISTRATIVE CAPACITY

The ability of an MCP to meet administrative requirements has been found to be both an indicator of current plan performance and a predictor of future performance. Deficiencies in administrative capacity make the accurate assessment of performance in other categories difficult, with findings uncertain. Performance in this category will be determined by the Compliance Assessment System, and the Emergency Department Diversion and Pharmaceutical Utilization Management measures described below. For a comprehensive description of the emergency department diversion measure, see *ODJFS Methods for the Administrative Capacity Performance Measure for the ABD Program*, and *ODJFS Methods for the Administrative Capacity Performance Measure for the CFC Program*. For a comprehensive description of the Pharmaceutical Utilization Management measures, see *ODJFS Methods for the Pharmaceutical Utilization Management Measures for the ABD Program*, and *ODJFS Methods for the Pharmaceutical Utilization Management Measures for the CFC Program*.

### 4.a. Compliance Assessment System–

*ABD / CFC Measure:* The number of points accumulated during a rolling 12-month period through the *Compliance Assessment System* (Appendix N).

*ABD / CFC Report Period:* For the SFY 2011 contract period, performance will be evaluated using a rolling 12-month report period.

*ABD / CFC Performance Standard:* A maximum of 15 points.

The penalties associated with accumulated points are outlined in Appendix N, *Compliance Assessment System.*

### 4.b. Emergency Department Diversion

Managed care plans must provide access to services in a way that assures access to primary and urgent care in the most effective settings and minimizes inappropriate utilization of emergency department (ED) services. MCPs are required to identify high utilizers of targeted ED services and implement action plans designed to minimize inappropriate, preventable, and/or primary care sensitive ED utilization.

*ABD / CFC Measure:* The percentage of members who had two or more *targeted* ED visits during the twelve month reporting period.

*ABD / CFC Report Period:*
For the SFY 2010 contract period, results will be calculated for the reporting period of CY 2009

and compared to the CY 2008 baseline results to determine if the regional-based Statewide Minimum Performance Standard is met. For the SFY 2011 contract period, results will be calculated for the reporting period of CY 2010 and compared to the CY 2009 baseline results to determine if the regional-based Statewide Minimum Performance Standard is met.

*ABD / CFC Regional-Based Statewide Approach:*
MCPs will be evaluated statewide, using results for all active regions in which the MCP has membership.

*ABD / CFC Regional-Based Statewide Target:*
SFY 2010 and SFY 2011 –
For the ABD Program: a maximum of 5.00% of the eligible population will have two or more targeted ED visits during the reporting period.
For the CFC Program: a maximum of 3.00% of the eligible population will have two or more targeted ED visits during the reporting period.

*ABD / CFC Regional-Based Statewide Minimum Performance Standard:*
For SFY 2010 and SFY 2011, the level of improvement must result in at least a 10% decrease in the difference between the target and the baseline period results.

The penalty for noncompliance with the standard for this measure is listed in Appendix N, *Compliance Assessment System.*

Effective SFY 2012, this measure will be included in the P4P Incentive System, as established in Appendix O, *Pay-for-Performance (P4P).*

**4.c. Pharmaceutical Utilization Management**

Despite the carve out of the pharmacy benefit from the Medicaid Managed Care Program, managed care plans must continue to provide utilization management of pharmaceuticals for their members. Furthermore, managed care members' pharmaceutical utilization patterns before and after the pharmacy benefit was carved out of managed care are expected to remain consistent.

**4.c.i. Overall Pharmaceutical Utilization Rate** *(applicable to performance evaluation beginning SFY 2011)*

ABD / CFC *Measure:* The total number of paid prescriptions per 1,000 member months.

*ABD / CFC Report Period:* For the SFY 2011 contract period: April – June 2010 (baseline), July – December 2010, and January – June 2011. For the SFY 2012 contract period: report periods TBD.

Note: The April – June 2010 report period results will be used as a baseline to set the targets and standards for SFY 2011. In addition, historical pharmaceutical utilization patterns for ABD and CFC Medicaid Managed Care programs will be taken into account when setting the performance targets and standards to encourage consistent utilization rates.

*ABD / CFC Regional-Based Statewide Target:*
SFY 2011 –
For the ABD Program: a maximum utilization rate of 7,360 prescriptions per 1,000 member months during the reporting period.
For the CFC Program: a maximum utilization rate of 1,200 prescriptions per 1,000 member months during the reporting period.

*ABD / CFC Regional-Based Statewide Minimum Performance Standard:*
For SFY 2011, the MCP meets the performance standard if either: the overall pharmacy utilization rate meets the target; or the level of improvement results in at least a 5.0% decrease in the difference between the target and the previous period's results.

The penalty for noncompliance with the standard for this measure is listed in Appendix N, *Compliance Assessment System.*

This measure is included in the P4P Pharmacy Carve-Out Incentive System, as established in Appendix O, *Pay-for-Performance (P4P).*

**4.c.ii. Generic Pharmaceutical Penetration Rate** *(applicable to performance evaluation beginning SFY 2011)*

ABD / CFC *Measure:* The total number of paid generic prescriptions divided by the total number of paid brand and generic prescriptions.

*ABD / CFC Report Period:* For the SFY 2011 contract period: April – June 2010 (baseline), July – December 2010, and January – June 2011. For the SFY 2012 contract period: report periods TBD.

Note: The April – June 2010 report period results will be used as a baseline to set the targets and standards for SFY 2011. Historical pharmaceutical utilization patterns for ABD and CFC Medicaid Managed Care programs will be taken into account when setting the performance targets and standards to encourage consistent utilization rates. In addition, ODJFS will consider changes in generic pharmaceutical utilization that may occur with the administration of ODJFS' preferred drug list.

*ABD / CFC Regional-Based Statewide Target:*
SFY 2011 –
For the ABD Program: a minimum utilization rate of .54 generic/total prescriptions during the reporting period.
For the CFC Program: a minimum utilization rate of .54 generic/total prescriptions during the reporting period.

*ABD / CFC Regional-Based Statewide Minimum Performance Standard:*
For SFY 2011, the MCP meets the performance standard if either: the generic pharmaceutical

penetration rate meets the target; or the level of improvement results in at least a 5.0% decrease in the difference between the target and the previous period's results.

The penalty for noncompliance with the standard for this measure is listed in Appendix N, *Compliance Assessment System.*

This measure is included in the P4P Pharmacy Carve-Out Incentive System, as established in Appendix O, *Pay-for-Performance (P4P).*

# APPENDIX N

# COMPLIANCE ASSESSMENT SYSTEM

## I. General Provisions of the Compliance Assessment System

A. The CAS does not prevent ODJFS' ability to require CAPs and program improvements, or to impose any of the sanctions specified in OAC rule 5101:3-26-10, including the proposed termination, amendment, or nonrenewal of the MCP's Provider Agreement.

B. As stipulated in OAC rule 5101:3-26-10(F), regardless of whether ODJFS imposes a sanction, MCPs are required to initiate corrective action for any MCP program violations or deficiencies as soon as they are identified by the MCP or ODJFS. In the event the MCP identifies a violation which could impair a member's ability to obtain correct information regarding services; impair member rights; affects the ability of the MCP to deliver covered services; or affects the member's ability to access covered services, the MCP is required to report to ODJFS when they become aware.

C. If ODJFS determines that an MCP has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act which are not specifically identified within the CAS, ODJFS may, pursuant to the provisions of OAC rule 5101:3-26-10(A), notify the MCP's members that they may disenroll from the MCP without cause and/or suspend any further new member enrollments.

D. Program violations that technically reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODJFS first becomes aware of this noncompliance.

E. In cases where an MCP contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), ODJFS will not assess points if: (1) the MCP can document that they provided sufficient notification/ education to providers of applicable program requirements and prohibited activities; and (2) the MCP takes immediate and appropriate action to correct the problem and to ensure that it does not happen again to the satisfaction of ODJFS. Repeated incidents will be reviewed to determine if the MCP has a systemic problem in this area, and if so, sanctions/remedial actions may be assessed, as determined by ODJFS.

F. All notices of noncompliance will be issued in writing to the identified MCP contact.

G. ODJFS retains the right to use its sole discretion to determine and apply the most appropriate penalty based on the severity of the offense, pattern of repeated noncompliance, and number of consumers affected.

## II. Types of Sanctions/Remedial Actions

ODJFS may impose sanctions/remedial actions, including, but not limited to, the items listed below.

A. Corrective Action Plans (CAPs) – A CAP is a structured activity/process implemented by the MCP to improve identified operational deficiencies.

MCPs may be required to develop CAPs for any instance of noncompliance, and CAPs are not limited to actions taken in this Appendix. All CAPs requiring ongoing activity on the part of an MCP to ensure their compliance with a program requirement remain in effect for twenty-four months.

In situations where ODJFS has already determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a CAP, ODJFS may require the MCP to comply with an ODJFS-developed or "directed" CAP.

In situations where a penalty is assessed for a violation in which an MCP has previously been assessed a CAP (or any penalty or any other related written correspondence), the MCP may be assessed escalating penalties.

B. Quality Improvement Directives (QIDs) – A QID is a general instruction that directs the MCP to implement a quality improvement initiative to improve identified administrative or clinical deficiencies. All QIDs remain in effect for twelve months from the date of implementation. MCPs may be required to develop QIDs for any instance of noncompliance. In situations where ODJFS has already determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a QID, ODJFS may require the MCP to comply with an ODJFS-developed or "directed" QID.
In situations where a penalty is assessed for a violation an MCP has previously been assessed a QID (or any penalty or any other related written correspondence), the MCP may be assessed escalating penalties.

C. Quality Improvement Plan (QIP) – A QIP is a written description of a MCP's process to improve access and quality of care in a clinical or administrative area. A QIP consists of three components: data analysis, root cause analysis, and the resulting quality improvement initiative, including the implementation and completion timeline. QIPs will be required when an MCP must comply with interim performance measure standards as specified by ODJFS.

D. Points – Points will accumulate over a rolling 12-month schedule. Each month, points that are more than 12-months old will expire.

No points will be assigned for any violation where an MCP is able to document that the precipitating circumstances were completely beyond their control and could not have been foreseen (e.g., a construction crew severs a phone line, a lightning strike blows a computer system, etc.).

D.1. 5 Points - Failures to meet program requirements, including but not limited to, actions which could impair the member's ability to obtain correct **information** regarding services or which could impair a consumer's or member's rights, as determined by ODJFS, will result in the assessment of 5 points. Examples include, but are not limited to, the following:

- Violations which result in a member's MCP selection or termination based on inaccurate provider panel information from the MCP.
- 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 their right to a state hearing when the MCP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to staff 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 health care providers, the MCP's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify ODJFS or members of provider panel terminations.
- Failure to update website provider directories as required.
- Failure to comply with a CAP or QID.

D.2. 10 Points - Failures to meet program requirements, including but not limited to, actions which could affect the ability of the MCP to deliver or the **consumer to access** covered services, as determined by ODJFS. 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 request from the member.
- Failure to provide medically-necessary Medicaid covered services to members.
- Failure to process prior authorization requests within the prescribed time frames.
- Repeated failure to comply with a CAP or QID.
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Misrepresents or falsifies information that it furnishes to CMS or to ODJFS.
- Misrepresents or falsifies information that it 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.

E. Fines – Refundable or nonrefundable fines may be assessed as a penalty separate to or in combination with other sanctions/remedial actions.

E.1. Unless otherwise stated, all fines are nonrefundable.

E.2. Refundable and nonrefundable monetary sanctions/assurances must be remitted to ODJFS within thirty (30) days, or as directed by ODJFS in writing, of receipt of the invoice by the MCP. In addition, per ORC Section 131.02, payments not received within forty-five (45) days will be certified to the Attorney General's (AG's) office. MCP payments certified to the AG's office will be assessed the appropriate collection fee by the AG's office.

E.3. Monetary sanctions/assurances imposed by ODJFS will be based on the most recent premium payments in the month of the cited deficiency.

E.4. Any monies collected through the imposition of a refundable fine will be returned to the MCP (minus any applicable collection fees owed to the AG's Office if the MCP has been delinquent in submitting payment) after they have demonstrated full compliance, as determined by ODJFS, with the particular program requirement.

E.5. MCPs are required to submit a written request for refund to ODJFS at the time they believe is appropriate before a refund of monies will be considered.

F. Combined Remedies - Notwithstanding any other action ODJFS may take under this Appendix, ODJFS may impose a combined remedy which will address multiple areas of noncompliance if ODJFS determines, in its sole discretion, that (1) one systemic problem is responsible for multiple areas of noncompliance and/or (2) that there are a number of repeated instances of noncompliance with the same program requirement. The total fines assessed in any one month will not exceed 15% of one month's payment from ODJFS to the MCP.

G. Progressive Remedies - Progressive remedies will be based on the number of points accumulated at the time of the most recent incident. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

| | |
|---|---|
| 0 -15 Points | CAP |
| 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 Contract Termination |

H. New Enrollment Freezes - Notwithstanding any other penalty or point assessment that ODJFS may impose on the MCP under this Appendix, ODJFS may prohibit an MCP from receiving new enrollment through consumer initiated selection or the assignment process if: (1) the MCP has

accumulated a total of 51 or more points during a rolling 12-month period; or (2) the MCP fails to fully implement a CAP within the designated time frame; or (3) circumstances exist which potentially jeopardize the MCP's members' access to care; or (4) the MCP is found to have a pattern of repeated or ongoing noncompliance. Examples of circumstances that ODJFS may consider as jeopardizing member access to care include:

- the MCP has been found by ODJFS to be noncompliant with the prompt payment or the non-contracting provider payment requirements;

- the MCP has been found by ODJFS to be noncompliant with the provider panel requirements specified in Appendix H of the Agreement;

- the MCP's refusal to comply with a program requirement after ODJFS has directed the MCP to comply with the specific program requirement; or

- the MCP has received notice of proposed or implemented adverse action by the ODI.

Payments provided for under the Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.730.

I. Reduction of Assignments – ODJFS has sole discretion over how member auto-assignments are made. ODJFS may reduce the number of assignments an MCP receives to assure program stability within a region or if ODJFS determines that the MCP lacks sufficient capacity to meet the needs of the increased enrollment volume. Examples of circumstances which ODJFS may determine demonstrate a lack of sufficient capacity include, but are not limited to an MCP's failure to: maintain an adequate provider network; repeatedly provide new member materials by the member's effective date; meet the minimum call center requirements; meet the minimum performance standards for members with special health care needs; and/or provide complete and accurate appeal/grievance, member's PCP and CAMS data files.

J. Termination, Amendment, or Nonrenewal of MCP Provider Agreement.- ODJFS can at any time move to terminate, amend or deny issuance of a provider agreement. Upon such termination, nonrenewal, or denial of an MCP provider agreement, all previously collected monetary sanctions will be retained by ODJFS. The at-risk amount paid to the MCP under the current provider agreement will be returned to ODJFS in accordance with Appendix P, *Terminations*, of the provider agreement.

K. Specific Pre-Determined Penalties

K.1. Adequate network-minimum provider panel requirements - Compliance with provider panel requirements will be assessed quarterly. Any deficiencies in the MCP's provider network as specified in Appendix H of the Agreement or by ODJFS, will result in the assessment of a

$1,000 nonrefundable fine for each category (practitioners, PCP capacity, hospitals), for each county, and for each population (e.g., ABD, CFC). For example if the MCP did not meet the following minimum panel requirements, the MCP would be assessed (1) a $3,000 nonrefundable fine for the failure to meet CFC panel requirements; and, (2) a $1,000 nonrefundable fine for the failure to meet ABD panel requirements).

- practitioner requirements in Franklin county for the CFC population
- practitioner requirements in Franklin county for the ABD population
- hospital requirements in Franklin county for the CFC population
- PCP capacity requirements in Fairfield county for the CFC population

In addition to the pre-determined penalties, ODJFS may assess additional penalties pursuant to this Appendix (e.g. CAPs, points, fines) if member specific access issues are identified resulting from provider panel noncompliance.

K.2. GIS - Compliance with the GIS requirements may be assessed semi-annually. Any failure to meet GIS requirements as specified in Appendix H of the Agreement will result a $1,000 nonrefundable fine for each county and for each population (e.g., ABD, CFC, etc.). For example if the MCP did not meet GIS requirements in the following counties, the MCP would be assessed (1) a nonrefundable $2,000 fine for the failure to meet GIS requirements for the CFC population and (2) a $1,000 nonrefundable fine for the failure to meet GIS requirements for the ABD population.

- GIS requirements in Franklin county for the CFC population
- GIS requirements in Fairfield county for the CFC population
- GIS requirements in Franklin county for the ABD population

K.3. Late Submissions - All required submissions/data and documentation requests must be received by their specified deadline and must represent the MCP in an honest and forthright manner. Failure to provide ODJFS with a required submission or any data/documentation requested by ODJFS will result in the assessment of a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODJFS. Assessments for late submissions will be done monthly. Examples of such program violations include, but are not limited to:

- Late required submissions
  - Annual delegation assessments
  - Call center report
  - State hearing notifications

- Late required data submissions
  - Appeals and grievances, care management, or PCP data
- Late required information requests
  - Automatic call distribution reports
  - Information/resolution regarding consumer or provider complaint
  - Just cause or other coordination care request from ODJFS
  - Failure to provide ODJFS with a required submission after ODJFS has notified the MCP that the prescribed deadline for that submission has

passed

If an MCP determines that they will be unable to meet a program deadline or data/documentation submission deadline, the MCP 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. Extension requests should only be submitted in situations where unforeseeable circumstances have occurred which make it impossible for the MCP to meet an ODJFS-stipulated deadline and all such requests will be evaluated upon this standard. Only written approval as may be granted by ODJFS of a deadline extension will preclude the assessment of compliance action for untimely submissions.

K.4. Noncompliance with Claims Adjudication Requirements - If ODJFS finds that an MCP is unable to (1) electronically accept and adjudicate claims to final status and/or (2) notify providers of the status of their submitted claims, as stipulated in Appendix C of the Agreement, ODJFS will assess the MCP with a monetary sanction of $20,000 per day for the period of noncompliance.

If ODJFS has identified specific instances where an MCP has failed to take the necessary steps to comply with the requirements specified in Appendix C of the Agreement for (1) failing to notify non-contracting providers of procedures for claims submissions when requested and/or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the MCP will be assessed 5 points per incident of noncompliance.

K.5. Noncompliance with Financial Performance Measures and/or the Submission of Financial Statements - Failure to meet any standard for 2.a., 2.b., or 2.c. of Appendix J will result in ODJFS requiring the MCP to complete a CAP and specifying the date by which compliance must be demonstrated. Failure to meet the standard or otherwise comply with the CAP by the specified date will result in a new enrollment freeze unless ODJFS determines that the deficiency does not potentially jeopardize access to or quality of care or affect the MCP's ability to meet administrative requirements (e.g., prompt pay requirements). Justifiable reasons for noncompliance may include one-time events (e.g., MCP investment in information system products).

If Financial Statements are not submitted to ODI by the due date, the MCP continues to be obligated to submit the report to ODJFS by ODI's originally specified due date unless the MCP requests and is granted an extension by ODJFS.

Failure to submit complete quarterly and annual Financial Statements on a timely basis will be deemed a failure to meet the standards and will be subject to the noncompliance penalties listed above for indicators 2.a., 2.b., and 2.c., including the imposition of a new enrollment freeze. The new enrollment freeze will take effect at the first of the month following the month in which the determination was made that the MCP was non-compliant for failing to submit financial reports timely.

K.6. Noncompliance with Reinsurance Requirements - If it is determined that an MCP failed to have reinsurance coverage as specified in Appendix J, that an MCP's deductible exceeds $75,000.00 without approval from ODJFS, or that the MCP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODJFS, then the MCP will be required to pay a monetary penalty to ODJFS. The amount of the penalty will be the difference between the estimated amount, as determined by ODJFS, of what the MCP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCP did actually pay while it was out of compliance plus 5%. For example, if the MCP paid $3,000,000.00 in premiums during the period of non-compliance and would have paid $5,000,000.00 if the requirements had been met, then the penalty would be $2,100,000.00.

If it is determined that an MCP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, the MCP will be required to develop a CAP.

K.7. Noncompliance with Prompt Payment: - Noncompliance with the prompt pay requirements as specified in Appendix J of the Agreement will result in progressive penalties. The first violation during a rolling 12-month period will result in the submission of quarterly prompt pay and monthly status reports to ODJFS until the next quarterly report is due. The second violation during a rolling 12-month period will result in the submission of monthly status reports and a refundable fine equal to 5% of the MCP's monthly premium payment or $300,000, whichever is less. The refundable fine will be applied in lieu of a nonrefundable fine and the money will be refunded by ODJFS only after the MCP complies with the required standards for two (2) consecutive quarters. Subsequent violations will result in an enrollment freeze.

If an MCP is found to have not been in compliance with the prompt pay requirements for any time period for which a report and signed attestation have been submitted representing the MCP as being in compliance, the MCP will be subject to an enrollment freeze of not less than three (3) months duration.

K.8. Noncompliance with Clinical Laboratory Improvement Amendments (CLIA)- Noncompliance with CLIA requirements as specified by ODJFS will result in the assessment of a nonrefundable $1,000 fine for each violation.

K.9. Noncompliance with Abortion and Sterilization Hysterectomy Requirements - Noncompliance with abortion and sterilization requirements as specified by ODJFS will result in the assessment of a nonrefundable $2,000 fine for each documented violation. Additionally, MCPs must take all appropriate action to correct each ODJFS-documented violation.

K.10. Refusal to Comply with Program Requirements - If ODJFS has instructed an MCP that they must comply with a specific program requirement and the MCP refuses, such refusal constitutes documentation that the MCP is no longer operating in the best interests of the MCP's members or the state of Ohio and ODJFS will move to terminate or non-renew the MCP's provider agreement.

K.11. Data Quality Submission Requirements and Measures (as specified in Appendix L) - The MCP must submit to ODJFS, by the specified deadline and according to ODJFS' specifications, all required data files and requested documentation needed to calculate each measure listed under K.11.b. and K.11.c. below. If an MCP fails to comply with this requirement for any measure listed under K.11.b. and K.11.c. below, the MCP will be considered noncompliant with the standard(s) for that measure.

ODJFS reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

The monetary penalty for each measure listed under K.11.b. and K.11.c. below shall not exceed $300,000 during each evaluation period.

K.11.a. Data Quality Submission Requirements

K.11.a.i. Annual Submission of MCP Self-Reported, Audited HEDIS Data – Performance is monitored annually. For SFY 2011, if an MCP fails to submit its self-reported, audited HEDIS data per *ODJFS Methodology for MCP Self-Reported, Audited HEDIS Results* within the required time frame, ODJFS will impose a nonrefundable monetary sanction of one percent of the MCP's premium payment for the applicable program(s) (e.g., CFC and/or ABD) paid to the MCP for the month the data was due. Effective SFY 2012, if an MCP fails to submit its self-reported, audited HEDIS data to ODJFS within the required time frame, the MCP will be considered non-compliant with all of the self-reported, audited HEDIS performance measures in Appendix M. In addition, the MCP will be disqualified from participation in the P4P incentive system for that year.

K.11.a.ii. Annual Submission of Final HEDIS Audit Report (FAR) – Performance is monitored annually. For SFY 2011, if an MCP fails to submit its final HEDIS audit report that contains the audited results for Ohio's Medicaid HEDIS production process, per *ODJFS Methodology for MCP Self-Reported, Audited HEDIS Results,* to ODJFS within the required time frame, ODJFS will impose a nonrefundable monetary sanction of one-half of one percent of the MCP's premium payment for the applicable program(s) (e.g., CFC and/or ABD) paid to the MCP for the month the audit report was due. Effective SFY 2012, if an MCP fails to submit its FAR that contains the audited results for Ohio's Medicaid HEDIS production process to ODJFS within the required time frame, the MCP will be considered non-compliant with all of the self-reported, audited HEDIS performance measures in Appendix M. In addition, the MCP will be disqualified from participation in the P4P incentive system for that year.

Note, ODJFS will review each MCP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODJFS will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. MCPs may be required to submit to ODJFS requested documentation to account for an NR audit designation. Based on its review of an MCP's FAR and any NR audit designations assigned, ODJFS reserves the right to pursue corrective action (such as requiring the MCP to implement a corrective action plan to

resolve data collection and/or reporting issues), as well as to not use the MCP's self-reported, audited HEDIS data to evaluate the MCP's performance on one or more HEDIS performance measures and/or to determine the status of an MCP's at-risk amount and any additional P4P payments.

K.11.a.iii. IDSS Data Submission and Audit Report Procedures (Data Certification Letters) - Performance is monitored annually. If an MCP fails to submit a required data certification letter to ODJFS within the required time frame, ODJFS will impose a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODJFS.

K.11.b. Data Quality Measures Assessed Separately By Program – For the following measures, performance is monitored and reported separately for each program (i.e., ABD, CFC) the MCP serves, as specified in Appendix L. Penalties for non-compliance are assessed separately for each program the MCP serves.

K.11.b.i. Encounter Data Volume - Performance is monitored once every quarter for the entire report period for each program the MCP serves. Penalties will be assessed by program. If the standard is not met for every service category in all quarters of the report period, the MCP will be determined to be noncompliant for the report period.

ODJFS will issue a Sanction Advisory for all instances of noncompliance with this measure that are NOT consecutive. ODJFS will issue a series of progressive penalties for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODJFS will issue a Sanction Advisory. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODJFS will impose a monetary sanction of two percent of the current month's premium payment per applicable population served pursuant to Appendix B. (Monetary sanctions will not be levied in subsequent, consecutive quarters that an MCP is determined to be noncompliant.) If an MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODJFS will impose a new member enrollment freeze. Once the MCP is determined to be compliant with the standard and the violations/ deficiencies are resolved to the satisfaction of ODJFS, any applicable penalties will be lifted (e.g., CAP, enrollment freeze, reduction of assignments), and any applicable monetary sanctions will be returned.

K.11.b.ii. Incomplete Data for LMP– Compliance with this measure is only assessed for MCPs serving the CFC Program. ODJFS will issue a Sanction Advisory for all instances of noncompliance with this measure that are not consecutive. ODJFS will issue progressive penalties for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODJFS will issue a Sanction Advisory. If an MCP is determined to be noncompliant with the standard in a second, consecutive report period, ODJFS will impose a monetary sanction of one percent of the current month's premium payment. Once the MCP is determined to be compliant with the standard and the

violations/deficiencies are resolved to the satisfaction of ODJFS, any applicable monetary sanctions will be returned.

K.11.b.iii. Encounter Data Accuracy Study

Delivery Payment Measure – Compliance with this measure is only assessed for MCPs serving the CFC program. The MCP must participate in a detailed review of delivery payments made for deliveries during the report period. The accuracy rate for encounters generating delivery payments is 100%; therefore, any duplicate delivery payments or delivery payments that are not validated must be returned to ODJFS. For all encounter data accuracy studies that are completed during this contract period, if an MCP does not meet the minimum record submittal rate of 85%, ODJFS will impose a non-refundable $10,000 monetary sanction. However, no monetary sanctions will be imposed if the MCP is in its first contract year of Medicaid program participation.

K.11.b.iv. IDSS Data Quality Reconciliation Measure - Beginning SFY 2012, if an MCP is noncompliant with the standard for this measure, the MCP must implement a corrective action plan which identifies interventions and a timeline for resolving data quality issues related to this measure. Additional reports to ODJFS addressing targeted areas of deficiencies and progress implementing data quality improvement activities may be required.

K.11.c. Data Quality Measures Assessed For All Programs An MCP Serves - For the following measures, performance is monitored and reported for all programs (i.e., ABD, CFC) the MCP serves, as specified in Appendix L. Penalties for noncompliance are assessed at the MCP level per measure and apply to all programs an MCP serves.

K.11.c.i. Incomplete Outpatient Hospital Data - Performance is monitored once every quarter for all report periods. For quarterly reports that are issued on or after July 1, 2007, an MCP will be determined to be noncompliant for the quarter if the standard is not met in any report period and the initial instance of noncompliance in a report period is determined on or after July 1, 2007. An initial instance of noncompliance means that the result for the applicable report period was in compliance as determined in the prior quarterly report, or the instance of noncompliance is the first determination for an MCP's first quarter of measurement.

ODJFS will issue a Sanction Advisory for all instances of noncompliance with this measure that are NOT consecutive. ODJFS will issue progressive penalties for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODJFS will issue a Sanction Advisory. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODJFS will impose a monetary sanction of one percent of the current month's premium payment. However, no monetary sanctions will be imposed if the MCP is in its first contract year of Medicaid program participation. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, any applicable monetary sanctions will be returned.

K.11.c.ii. Rejected Encounters - Performance is monitored once every quarter for Measure 1 and once every month for Measure 2. Compliance determination with the standard applies only to the report period under consideration and does not include performance in previous report periods. Files in the ODJFS-specified medium per format that are totally rejected will not be considered in the determination of noncompliance.

ODJFS will issue a Sanction Advisory for all instances of noncompliance with this measure that are NOT consecutive. ODJFS will issue progressive penalties for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODJFS will issue a Sanction Advisory. If an MCP is determined to be noncompliant with the standard in a second, consecutive report period, ODJFS will impose a monetary sanction of one percent of the current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, any applicable monetary sanctions will be returned. Special consideration will be made for MCPs with less than 1,000 members. -

K.11.c.iii. Acceptance Rate - Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months.

If the MCP is determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of one percent of the MCP's current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance. The monetary sanction will be applied only once per file type per compliance determination period and will not exceed a total of two percent of the MCP's current month's premium payment. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, any applicable monetary sanctions will be returned . Special consideration will be made for MCPs with less than 1,000 members.

K.11.c.iv. Encounter Data Accuracy Study

Payment Accuracy Measure - Beginning SFY 2010, the first time an MCP is determined to be noncompliant with the standard for either level 1 or level 2 for this measure, the MCP must implement a CAP which identifies interventions and a timeline for resolving data quality issues related to payments. Additional reports to ODJFS addressing targeted areas of deficiencies and progress implementing data quality improvement activities may be required. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard for either level 1 or level 2 for this measure, ODJFS will impose a monetary sanction of one percent of the current month's premium payment. Once the MCP is determined to be compliant with the standard for level 1 and level 2 for this measure and the violations/deficiencies are resolved to the satisfaction of ODJFS, any applicable monetary sanctions will be returned.

K.11.c.v. Generic Provider Number Usage

Performance is monitored once every quarter for all report periods. For quarterly reports that are issued on or after July 1, 2007, an MCP will be determined to be noncompliant for the quarter if the standard is not met in any report period and the initial instance of noncompliance in a report period is determined on or after July 1, 2007. An initial instance of noncompliance means that the result for the applicable report period was in compliance as determined in the prior quarterly report, or the instance of noncompliance is the first determination for an MCP's first quarter of measurement.

ODJFS will issue a Sanction Advisory for all instances of noncompliance with this measure that are NOT consecutive. ODJFS will issue progressive penalties for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODJFS will issue a Sanction Advisory. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODJFS will impose a monetary sanction of three percent of the current month's premium payment. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, any applicable monetary sanctions will be returned .

K.12. Performance Evaluation Measures (as specified in Appendix M) - The MCP must submit to ODJFS, by the specified deadline and according to ODJFS' specifications, all required data files and requested documentation needed to calculate each measure listed under K.12. below. If an MCP fails to comply with this requirement for any measure listed under K.12. below, the MCP will be considered noncompliant with the standard(s) for that measure.

Effective February 1, 2010, ODJFS carved the pharmacy benefit out of the Medicaid Managed Care Program. The impact of this policy change on the measures listed under K.12. below is not yet known. ODJFS reserves the right to apply the most appropriate penalty or withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

The monetary penalty for each measure listed under K.12. below shall not exceed $300,000 during each evaluation period.

K.12.i. ABD / CFC Independent External Quality Review - For these review studies, performance will either be monitored and reported separately for each program, or together across all programs, (i.e., ABD, CFC), the MCP serves. Penalties will be assessed per study. For all reviews conducted during the contract period, if the EQRO cites a deficiency in performance the MCP will be required to complete a Corrective Action Plan or Quality Improvement Directive, depending on the severity of the deficiency. Serious deficiencies may result in immediate termination or non-renewal of the Agreement.

K.12.ii. ABD / CFC Care Management of Members - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. ODJFS will issue a Sanction Advisory for all instances of noncompliance

with this measure that are NOT consecutive. ODJFS will issue a series of progressive penalties for consecutive instances of noncompliance. Beginning SFY 2010, the first time an MCP is determined to be noncompliant with the standard for this measure, ODJFS will issue a Sanction Advisory. If an MCP is determined to be noncompliant with the standard in a second, consecutive report period, ODJFS will direct the MCP to implement a CAP which identifies interventions and a timeline for resolving care management issues. (Additional reports to ODJFS addressing targeted areas of deficiencies and progress implementing quality improvement activities may be required.) If an MCP is determined to be noncompliant with the standard in a third, consecutive report period, ODJFS will impose a monetary sanction of two percent of the current month's premium payment per applicable program. (Monetary sanctions will not be levied in subsequent, consecutive report periods that an MCP is determined to be noncompliant.) If an MCP is determined to be noncompliant with the standard in a fourth, consecutive report period, ODJFS will impose a new member enrollment freeze. If an MCP is determined to be noncompliant with the standard in a fifth, consecutive report period, ODJFS will impose a reduction of assignments. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, any applicable penalties will be lifted (e.g., CAP, enrollment freeze, reduction of assignments), and any applicable monetary sanctions will be returned.

K.12.iii. ABD / CFC Care Management of High Risk Members - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. ODJFS will issue a Sanction Advisory for all instances of noncompliance with this measure that are NOT consecutive. ODJFS will issue a series of progressive penalties for consecutive instances of noncompliance. Beginning SFY 2010, the first time an MCP is determined to be noncompliant with the standard for this measure, ODJFS will issue a Sanction Advisory If an MCP is determined to be noncompliant with the standard in a second, consecutive report period, ODJFS will impose a monetary sanction of two percent of the current month's premium payment per applicable program. (Monetary sanctions will not be levied in subsequent, consecutive report periods that an MCP is determined to be noncompliant.) If an MCP is determined to be noncompliant with the standard in a third, consecutive report period, ODJFS will impose a new member enrollment freeze. If an MCP is determined to be noncompliant with the standard in a fourth, consecutive report period, ODJFS will impose a reduction of assignments. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, any applicable penalties will be lifted (e.g., CAP, enrollment freeze, reduction of assignments),and any applicable monetary sanctions will be returned.

K.12.iv. Clinical Performance Measures

K.12.iv.a. ABD Clinical Performance Measures

All MCPs are held accountable to regional-based statewide targets and minimum performance standards for both one and two year measures.

For measures one through three in Table 1 below, if the MCP fails to meet the standard for the measure, the MCP will be required to take the following action:

1) If the MCP's results are greater than the percentage stated in Table 1 below, the MCP will be required to complete a CAP to address the area of noncompliance.
2) If the MCP's results are less than or equal to the percentage stated in Table 1 below, the MCP will be required to submit a QID that outlines the steps the MCP will take to improve the results.

For measures four through nine in Table 1 below, if the MCP fails to meet the standard for the measure, the MCP will be required to take the following action:

1) If the MCP's results are less than the percentage stated in Table 1 below, the MCP will be required to complete a CAP to address the area of noncompliance.
2) If the MCP's results are greater than or equal to the percentage stated in Table 1 below, the MCP will be required to submit a QID that outlines the steps the MCP will take to improve the results.

**Table 1. Results that Determine Penalties for ABD Clinical Performance Measures**

| Measure | SFY 2010 Results that Determine Penalty | SFY 2011 Results that Determine Penalty | SFY 2012 Results that Determine Penalty |
|---|---|---|---|
| 1. Inpatient Hospital Discharge Rate | 20 discharges/1,000 MM | 20 discharges/1,000 MM | TBD in October, 2011 |
| 2. Emergency Department Utilization Rate | 21 visits/1,000 MM | 21 visits/1,000 MM | TBD in October, 2011 |
| 3. Inpatient Hospital Readmission Rate | 19% | 19% | TBD in October, 2011 |
| 4. Coronary Artery Disease – Persistence of Beta Blocker Treatment after Heart Attack | 50% (NCQA HEDIS 2008, 25th Percentile) | 50% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| 5. Coronary Artery Disease – Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed | 74% (NCQA HEDIS 2008, 25th Percentile) | 74% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| 6. Diabetes – Eye Exam | 40% (NCQA HEDIS 2008, 25th Percentile) | 40% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| 7. Asthma – Use of Appropriate Medications | 86% (NCQA HEDIS 2008, 25th Percentile) | 86% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| 8. Follow Up after Hospitalization for Mental Illness (within 30 days) | 66% (NCQA HEDIS 2008, 50th Percentile) | 66% (NCQA HEDIS 2008, 50th Percentile) | TBD in October, 2011 |
| 9. Follow Up after Hospitalization for Mental Illness (within 7 days) | 43% (NCQA HEDIS 2008, 50th Percentile) | 43% (NCQA HEDIS 2008, 50th Percentile) | TBD in October, 2011 |

K.12.iv.b. CFC Clinical Performance Measures

All MCPs are held accountable to regional-based statewide targets and minimum performance standards for both one and two year measures.

For each measure listed in Table 2 below, if the MCP fails to meet the standard for the measure, the MCP will be required to take the following action:

1) Complete a CAP to address the area of noncompliance if the MCP's results are below the percentage stated in Table 2 below; or
2) Submit a QID that outlines the steps the MCP will take to improve the results, if the MCP's results are equal to or greater than the percentage stated in Table 2 below.

**Table 2. Results that Determine Penalties for CFC Clinical Performance Measures**

| Measure | SFY 2010 Regional-Based Results that Determine Penalty | SFY 2011 Regional-Based Results that Determine Penalty | SFY 2012 Regional-Based Results that Determine Penalty |
|---|---|---|---|
| Perinatal Care – Frequency of Ongoing Prenatal Care | 51% (NCQA HEDIS 2008, 25th Percentile) | 51% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| Perinatal Care – Timeliness of Prenatal Care | 77% (NCQA HEDIS 2008, 25th Percentile) | 77% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| Perinatal Care – Postpartum Care | 54% (NCQA HEDIS 2008, 25th Percentile) | 54% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| Preventive Care – 15 Month Old Age Group | 45% (NCQA HEDIS 2008, 25th Percentile) | 45% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| Preventive Care – 3 – 6 Year Old Age Group | 60% (NCQA HEDIS 2008, 25th Percentile) | 60% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| Adolescent Well-Care Visits | 36% (NCQA HEDIS 2008, 25th Percentile) | 36% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |

| | | | |
|---|---|---|---|
| Use of Appropriate Medications for People with Asthma | 86% (NCQA HEDIS 2008, 25th Percentile) | 86% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| Annual Dental Visits | 36% (NCQA HEDIS 2008, 25th Percentile) | 36% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |
| Lead Screening in Children | 49% (NCQA HEDIS 2008, 25th Percentile) | 49% (NCQA HEDIS 2008, 25th Percentile) | TBD in October, 2011 |

K.12.v. CFC Children's Access to Primary Care - If an MCP is noncompliant with the minimum performance standard, the MCP must develop and implement a corrective action plan.

K.12.vi. ABD Members' / CFC Adults' Access to Preventive/Ambulatory Health Services - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. If an MCP is noncompliant with the minimum performance standard, then the MCP must develop and implement a corrective action plan.

K.12.vii. ABD / CFC Consumer Satisfaction - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. If an MCP is determined noncompliant with the minimum performance standard, then the MCP must develop a corrective action plan and provider agreement renewals may be affected.

K.12.viii. ABD / CFC Emergency Department Diversion (EDD) - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. If the standard is not met, then the MCP must develop a corrective action plan, for which ODJFS may direct the MCP to develop the components of their targeted EDD program as specified by ODJFS.

K.12.ix. ABD / CFC Overall Pharmaceutical Utilization Rate - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. If the standard is not met, then the MCP must develop a corrective action plan, for which ODJFS may direct the MCP to develop the components of their pharmaceutical utilization management program as specified by ODJFS.

K.12.x. ABD / CFC Generic Pharmaceutical Penetration Rate - For these two measures, performance is monitored and reported for each program (i.e., ABD, CFC) the MCP serves. Penalties will be assessed by program. If the standard is not met, then the MCP must develop a corrective action plan, for which ODJFS may direct the MCP to develop the components of their pharmaceutical utilization management program as specified by ODJFS.

## III. Request for Reconsiderations

MCPs may request a reconsideration of remedial action taken under the CAS for penalties that include points, fines, reductions in assignments and/or enrollment freezes. Requests for reconsideration must be submitted on the ODJFS required form as follows:

A. MCPs notified of ODJFS' imposition of remedial action taken under the CAS will have ten (10) working days from the date of receipt of the notification to request reconsideration, although ODJFS will impose enrollment freezes based on an access to care concern concurrent with initiating notification to the MCP. Any information that the MCP would like reviewed as part of the reconsideration request must be submitted at the time of submission of the reconsideration request, unless ODJFS extends the time frame in writing.

B. All requests for reconsideration must be submitted by either email to the designated Contract Administrator (CA) or overnight mail to the Bureau of Policy and Health Plan Services (BPHPS), and received by ODJFS by the tenth business day after receipt of the notification of the imposition of the remedial action by ODJFS.

C. The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests for reconsideration must explain in detail why the specified remedial action should not be imposed. The MCP's justification for reconsideration will be limited to a review of the written material submitted by the MCP.

D. Final decisions or requests for additional information will be made by ODJFS within ten (10) business days of receipt of the request for reconsideration.

E. If additional information is requested by ODJFS, a final reconsideration decision will be made within three (3) business days of the due date for the submission. Should ODJFS require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.

F. If a reconsideration request is decided, in whole or in part, in favor of the MCP, both the penalty and the points associated with the incident, will be rescinded or reduced, in the sole discretion of ODJFS. The MCP may still be required to submit a CAP if ODJFS, in its sole discretion, believes that a CAP is still warranted under the circumstances.

# APPENDIX O

## PAY-FOR-PERFORMANCE (P4P)

Sections 1. and 2. of this Appendix established a pay-for-performance (P4P) Incentive System for MCPs to improve performance in specific areas important to Medicaid MCP members. P4P rewards under the Incentive System include the at-risk amount included with the monthly premium payments (see Appendix F), and possible additional monetary rewards up to $250,000 per program (i.e., ABD, CFC).

To qualify for consideration of P4P under the Incentive System, MCPs must meet Minimum Performance Standards established in Appendix M, *Performance Evaluation* on selected measures, and achieve P4P standards established for selected clinical performance measures, as set forth herein. For qualifying MCPs, higher performance standards for three measures must be reached to be awarded a portion of the at-risk amount and any additional monetary reward. An excellent and superior standard is set for each of the three measures. Qualifying MCPs will be awarded a portion of the at-risk amount for each excellent standard met. If an MCP meets all three excellent and superior standards, they may be awarded the additional monetary reward.

Note: ODJFS will make the following revisions to the P4P Incentive System (both the ABD and CFC programs) to become effective in SFY 2012: 1) incorporating the Emergency Department Diversion measure, 2) incorporating the use of performance-based auto-assignments, and 3) evaluating certain measures using MCP self-reported, audited HEDIS data.

Note: Effective February 1, 2010, ODJFS carved the pharmacy benefit out of the Medicaid Managed Care Program. The impact of this policy change on certain measures used in the P4P Incentive System is not yet known. Therefore, ODJFS reserves the right to adjust performance measure results with respect to the following P4P measures for the time periods indicated below:

**SFY 2010:** Care Management of High Risk Members (*CFC, ABD*); Consumer Satisfaction *(CFC, ABD)*; **SFY 2011:** Care Management of High Risk Members (*CFC, ABD*); Inpatient Hospital Discharge Rate *(ABD)*; Coronary Artery Disease – Persistence of Beta Blocker Treatment after Heart Attack *(ABD)*; Comprehensive Diabetes Care /Eye Exam (*ABD*); and Asthma - Use of Appropriate Medications for People with Asthma *(CFC, ABD)*.

Note: Effective SFY 2011, ODJFS is implementing a P4P Pharmacy Carve-Out Incentive System, per Sections 3. and 4. of this Appendix, to encourage MCPs to continue to manage pharmaceutical utilization of their members beyond the carve-out of the pharmacy benefit from the Medicaid Managed Care Program. The Pharmacy Carve-Out Incentives are awarded based on two specific performance measures defined in Sections 3. and 4. of this Appendix. The determination and provision of incentives under the P4P Pharmacy Carve-Out Incentive System are made independently of any determination and provision of incentives under the P4P Incentive System.

## 1. P4P INCENTIVE SYSTEM - ABD PROGRAM

All MCPs will be included in the statewide P4P Incentive System. The at-risk amount included in the statewide P4P Incentive System is calculated separately for each region that an MCP serves.

### 1.a. SFY 2010 ABD Program P4P

### 1.a.i. Qualifying Performance Levels

To qualify for consideration of the SFY 2010 P4P, an MCP's performance level must meet the Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for the measures listed below. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

Measures for which the Minimum Performance Standard for SFY 2010 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of incentives are as follows:

1. ABD Members' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.b.)

*Report Period*: CY 2009

2. ABD Overall Satisfaction with MCP Customer Service (Appendix M, Section 3.)

*Report Period:* The most recent consumer satisfaction survey completed prior to the end of SFY 2010.

For each ABD clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2010 P4P. The MCP meets the P4P standard if one of two criteria is met. The P4P standard is a performance level of either:

1) The Minimum Performance Standard established in Appendix M, *Performance Evaluation*, for four of the six ABD clinical performance measures listed in Table 1 below; or

2) The Medicaid Minimum Performance Level for four of the six ABD clinical performance measures listed in Table 1 below. The Medicaid Minimum Performance Levels are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

**Table 1. Medicaid Minimum Performance Levels**

| ABD Clinical Performance Measure | Medicaid Minimum Performance Level |
|---|---|
| 1. Inpatient Hospital Discharge Rate | 20 discharges/ 1,000 MM |
| 2. CAD: Persistence of Beta-Blocker Treatment after Heart Attack (AMI -related admission) | 50% (NCQA HEDIS 2008, 25th Percentile) |
| 3. CAD: Cholesterol Management for Patients with Cardiovascular Conditions/ LDL-C screening performed | 74% (NCQA HEDIS 2008, 25th Percentile) |
| 4. Diabetes: Comprehensive Diabetes Care (CDC)/Eye exam | 40% (NCQA HEDIS 2008, 25th Percentile) |
| 5. Asthma: Use of Appropriate Medications for People with Asthma | 86% (NCQA HEDIS 2008, 25th Percentile) |
| 6. Mental Health: Follow-up After Hospitalization for Mental Illness within 7 Days of Discharge | 43% (NCQA HEDIS 2008, 50th Percentile) |

**1.a.ii. Excellent and Superior Performance Levels**

For qualifying MCPs as determined by Section 1.a.i. herein, performance will be evaluated on the measures listed below to determine the status of the at-risk amount and any additional P4P that may be awarded. Excellent and superior standards are set for the three measures described below. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

1. ABD Care Management of High Risk Members (Appendix M, Section 1.b.ii.)

*Report Period*: April – June 2010

*Excellent Standard*: 46.7%

*Superior Standard*: 61.3%

2. ABD Comprehensive Diabetes Care (CDC)/Eye exam (Appendix M, Section 1.c.ii.)

*Report Period*: CY 2009

*Excellent Standard*: 39.7%

*Superior Standard*: 53.8%

3. ABD Members' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.b.)

*Report Period*: CY 2009

*Excellent Standard*: 81%

*Superior Standard*: 87%

**1.a.iii. Determining SFY 2010 P4P**

MCPs that do not meet the Minimum Performance Standards described in section 1.a.i. herein, will not be considered for P4P and must return to ODJFS one hundred percent of their at-risk amount used in the SFY 2010 P4P determination. MCPs reaching the Minimum Performance Standards described in Section 1.a.i. herein, will be considered for P4P including retention of the at-risk amount and any additional P4P. For each excellent standard established in Section 1.a.ii. herein, that an MCP meets, one-third of the at-risk amount may be retained. For MCPs meeting all of the excellent and superior standards established in Section 1.a.ii. herein, additional P4P may be awarded. For MCPs receiving additional P4P, the amount in the P4P fund will be divided equally, up to the maximum additional amount, among all MCPs' ABD and/or CFC programs receiving additional P4P. The maximum additional amount to be awarded per plan, per program, per contract year is $250,000. An MCP may receive up to $500,000 should both of the MCP's ABD and CFC programs achieve the superior performance levels.

**1.b. SFY 2011 ABD Program P4P**

**1.b.i. Qualifying Performance Levels**

To qualify for consideration of the SFY 2011 P4P, an MCP's performance level must meet the Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for the measures listed below. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

Measures for which the Minimum Performance Standard for SFY 2011 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of incentives are as follows:

1. ABD Members' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.b.)

*Report Period*: CY 2010

2. ABD Overall Satisfaction with MCP Customer Service (Appendix M, Section 3.)

*Report Period:* The most recent consumer satisfaction survey completed prior to the end of SFY 2011.

For each ABD clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2011 P4P. The MCP meets the P4P standard if one of two criteria is met. The P4P standard is a performance level of either:

1) The Minimum Performance Standard established in Appendix M, *Performance Evaluation*, for four of the six ABD clinical performance measures listed in Table 2 below; or

2) The Medicaid Minimum Performance Level for four of the six ABD clinical performance measures listed in Table 2 below. The Medicaid Minimum Performance Levels are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

**Table 2. Medicaid Minimum Performance Levels**

| ABD Clinical Performance Measure | Medicaid Minimum Performance Level |
|---|---|
| 1. Inpatient Hospital Discharge Rate | 20 discharges/ 1,000 MM |
| 2. CAD: Persistence of Beta-Blocker Treatment after Heart Attack (AMI -related admission) | 50% (NCQA HEDIS 2008, 25th Percentile) |
| 3. CAD: Cholesterol Management for Patients with Cardiovascular Conditions/ LDL-C screening performed | 74% (NCQA HEDIS 2008, 25th Percentile) |
| 4. Diabetes: Comprehensive Diabetes Care (CDC)/Eye exam | 40% (NCQA HEDIS 2008, 25th Percentile) |
| 5. Asthma: Use of Appropriate Medications for People with Asthma | 86% (NCQA HEDIS 2008, 25th Percentile) |
| 6. Mental Health: Follow-up After Hospitalization for Mental Illness within 7 Days of Discharge | 43% (NCQA HEDIS 2008, 50th Percentile) |

**1.b.ii. Excellent and Superior Performance Levels**

For qualifying MCPs as determined by Section 1.b.i. herein, performance will be evaluated on the measures listed below to determine the status of the at-risk amount and any additional P4P that may be awarded. Excellent and superior standards are set for the three measures described below. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

1. ABD Care Management of High Risk Members (Appendix M, Section 1.b.ii.)

*Report Period*: April – June 2011

*Excellent Standard*: 48.7%

*Superior Standard*: 62.0%

2. Follow Up After Hospitalization for Mental Illness within 7 Days of Discharge (Appendix M, Section 1.c.ii.)

*Report Period*: CY 2010

*Excellent Standard*: 48%

*Superior Standard*: 50%

3. ABD Members' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.b.)

*Report Period*: CY 2010

*Excellent Standard*: 83%

*Superior Standard*: 88%

**1.b.iii. Determining SFY 2011 P4P**

MCPs that do not meet the Minimum Performance Standards described in section 1.b.i. herein, will not be considered for P4P and must return to ODJFS one hundred percent of their at-risk amount used in the SFY 2011 P4P determination. MCPs reaching the Minimum Performance Standards described in Section 1.b.i. herein, will be considered for P4P including retention of the at-risk amount and any additional P4P. For each excellent standard established in Section 1.b.ii. herein, that an MCP meets, one-third of the at-risk amount may be retained. For MCPs meeting all of the excellent and superior standards established in Section 1.b.ii. herein, additional P4P may be awarded. For MCPs receiving additional P4P, the amount in the P4P fund will be divided equally, up to the maximum additional amount, among all MCPs' ABD and/or CFC programs receiving additional P4P. The maximum additional amount to be awarded per plan, per program, per contract year is $250,000. An MCP may receive up to $500,000 should both of the MCP's ABD and CFC programs achieve the superior performance levels.

**2. P4P INCENTIVE SYSTEM - CFC PROGRAM**

**2.a. SFY 2010 CFC Program P4P - Regional-Based Statewide P4P System**
All MCPs will be included in the regional-based statewide P4P Incentive System. The at-risk amount included in the statewide P4P Incentive System is calculated separately for each region an MCP serves.

The first regional-based statewide P4P Incentive System determination will be SFY 2010 and will include at-risk amounts from July, 2009 through June, 2010.

For MCPs with membership in the NEC region, this determination will include at-risk dollars from Columbiana county from March, 2010 through June, 2010 and at-risk dollars from Mahoning and Trumbull counties from July, 2009 through June, 2010.

**2.a.i. Qualifying Performance Levels**

To qualify for consideration of the SFY 2010 P4P, an MCP's performance level must meet the Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for the measures listed below. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

Measures for which the Minimum Performance Standard for SFY 2010 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of P4P are as follows:

1. CFC Children's Access to Primary Care (Appendix M, Section 2.a.)

*Report Period*: CY 2009

2. CFC Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.b.)

*Report Period*: CY 2009

3. CFC Overall Satisfaction with MCP Customer Service (Appendix M, Section 3.)

*Report Period*: The most recent consumer satisfaction survey completed prior to the end of SFY 2010.

For each CFC clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2010 P4P. The MCP meets the P4P standard if one of two criteria is met. The P4P standard is a performance level of either:

1) The Minimum Performance Standard established in Appendix M, *Performance Evaluation*, for seven of the nine CFC clinical performance measures listed in Table 3 below; or

2) The Medicaid Minimum Performance Level for seven of the nine CFC clinical performance measures listed in Table 3 below. The Medicaid Minimum Performance Levels are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

**Table 3. Medicaid Minimum Performance Levels**

| CFC Clinical Performance Measure | Medicaid Minimum Performance Level |
|---|---|
| 1. Perinatal Care - Frequency of Ongoing Prenatal Care | 51% (NCQA HEDIS 2008, 25th Percentile) |
| 2. Perinatal Care – Timeliness of Prenatal Care | 77% (NCQA HEDIS 2008, 25th Percentile) |
| 3. Perinatal Care - Postpartum Care | 54% (NCQA HEDIS 2008, 25th Percentile) |
| 4. Well-Child Visits – Children who turn 15 months old | 45% (NCQA HEDIS 2008, 25th Percentile) |
| 5. Well-Child Visits - 3, 4, 5, or 6, years old | 60% (NCQA HEDIS 2008, 25th Percentile) |
| 6. Adolescent Well-Care Visits | 36% (NCQA HEDIS 2008, 25th Percentile) |
| 7. Use of Appropriate Medications for People with Asthma | 86% (NCQA HEDIS 2008, 25th Percentile) |
| 8. Annual Dental Visits | 36% (NCQA HEDIS 2008, 25th Percentile) |
| 9. Lead Screening in Children | 49% (NCQA HEDIS 2008, 25th Percentile) |

**2.a.ii. Excellent and Superior Performance Levels**

For qualifying MCPs as determined by section 2.a.i. of this appendix, performance will be evaluated on the measures listed below to determine the status of the at-risk amount. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

1. CFC Care Management of High Risk Members (Appendix M, Section 1.b.ii.)

*Report Period*: April – June, 2010

*Excellent Standard*: 26.1%

*Superior Standard*: 32.4%

2. CFC Use of Appropriate Medications for People with Asthma (Appendix M, Section 1.c.ii.)

*Report Period*: CY 2009

*Excellent Standard:* 86.1%

*Superior Standard*: 88.7%

3. CFC Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.b.)

*Report Period*: CY 2009

*Excellent Standard*: 79%

*Superior Standard*: 85%

**2.a.iii. Determining SFY 2010 P4P**

MCPs that do not meet the Minimum Performance Standards described in section 2.a.i. herein will not be considered for P4P and must return to ODJFS one hundred percent of their at-risk amount used in the SFY 2010 P4P determination. MCPs reaching the Minimum Performance Standards described in section 2.a.i. herein will be considered for P4P (retention of the at-risk amount). For each excellent standard, established in section 2.a.ii. herein, that an MCP meets, one-third of the at-risk amount used in the SFY 2010 P4P determination may be retained. For MCPs meeting all of the excellent and superior standards established in Section 2.a.ii. herein, additional P4P may be awarded. For MCPs receiving additional P4P, the amount in the P4P fund will be divided equally, up to the maximum additional amount, among all MCPs' ABD and/or CFC programs receiving additional P4P. The maximum additional amount to be awarded per plan, per program, per contract year is $250,000. An MCP may receive up to $500,000 should both of the MCP's ABD and CFC programs achieve the superior performance levels.

**2.b. SFY 2011 CFC Program P4P**

**2.b.i. Qualifying Performance Levels**

To qualify for consideration of the SFY 2011 P4P, an MCP's performance level must meet the Minimum Performance Standards set in Appendix M, *Performance Evaluation*, for the measures listed below. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

Measures for which the Minimum Performance Standard for SFY 2011 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of P4P are as follows:

1. CFC Children's Access to Primary Care (Appendix M, Section 2.a.i.)

*Report Period*: CY 2010

2. CFC Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.b.)

*Report Period*: CY 2010

3. CFC Overall Satisfaction with MCP Customer Service (Appendix M, Section 3.)

*Report Period*: The most recent consumer satisfaction survey completed prior to the end of SFY 2011.

For each CFC clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2011 P4P. The MCP meets the P4P standard if one of two criteria is met. The P4P standard is a performance level of either:

1) The Minimum Performance Standard established in Appendix M, *Performance Evaluation*, for seven of the nine CFC clinical performance measures listed in Table 4 below; or

2) The Medicaid Minimum Performance Level for seven of the nine CFC clinical performance measures listed in Table 4 below. The Medicaid Minimum Performance Levels are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

**Table 4. Medicaid Minimum Performance Levels**

| CFC Clinical Performance Measure | Medicaid Minimum Performance Level |
|---|---|
| 1. Perinatal Care - Frequency of Ongoing Prenatal Care | 51% (NCQA HEDIS 2008, 25th Percentile) |
| 2. Perinatal Care – Timeliness of Prenatal Care | 77% (NCQA HEDIS 2008, 25th Percentile) |
| 3. Perinatal Care - Postpartum Care | 54% (NCQA HEDIS 2008, 25th Percentile) |
| 4. Well-Child Visits – Children who turn 15 months old | 45% (NCQA HEDIS 2008, 25th Percentile) |
| 5. Well-Child Visits - 3, 4, 5, or 6, years old | 60% (NCQA HEDIS 2008, 25th Percentile) |
| 6. Adolescent Well-Care Visits | 36% (NCQA HEDIS 2008, 25th Percentile) |
| 7. Use of Appropriate Medications for People with Asthma | 86% (NCQA HEDIS 2008, 25th Percentile) |
| 8. Annual Dental Visits | 36% (NCQA HEDIS 2008, 25th Percentile) |
| 9. Lead Screening in Children | 49% (NCQA HEDIS 2008, 25th Percentile) |

**2.b.ii. Excellent and Superior Performance Levels**

For qualifying MCPs as determined by section 2.b.i. of this appendix, performance will be evaluated on the measures listed below to determine the status of the at-risk amount. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

1. CFC Care Management of High Risk Members (Appendix M, Section 1.b.ii.)

*Report Period*: April – June, 2011

*Excellent Standard*: 37.6%

*Superior Standard*: 42.3%

2. Adolescent Well-Care Visits (Appendix M, Section 1.c.ii.)

*Report Period*: CY 2010

*Excellent Standard:* 37.9%

*Superior Standard*: 45.1%

3. CFC Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.b.)

*Report Period*: CY 2010

*Excellent Standard*: 80%

*Superior Standard*: 86%

**2.b.iii. Determining SFY 2011 P4P**

MCPs that do not meet the Minimum Performance Standards described in section 2.b.i. herein will not be considered for P4P and must return to ODJFS one hundred percent of their at-risk amount used in the SFY 2011 P4P determination. MCPs reaching the Minimum Performance Standards described in section 2.b.i. herein will be considered for P4P (retention of the at-risk amount). For each excellent standard, established in section 2.b.ii. herein, that an MCP meets, one-third of the at-risk amount used in the SFY 2011 P4P determination may be retained. For

MCPs meeting all of the excellent and superior standards established in Section 2.b.ii. herein, additional P4P may be awarded. For MCPs receiving additional P4P, the amount in the P4P fund will be divided equally, up to the maximum additional amount, among all MCPs' ABD and/or CFC programs receiving additional P4P. The maximum additional amount to be awarded per plan, per program, per contract year is $250,000. An MCP may receive up to $500,000 should both of the MCP's ABD and CFC programs achieve the superior performance levels.

## 3. P4P PHARMACY CARVE-OUT INCENTIVE SYSTEM - ABD PROGRAM

### 3.a. SFY 2011 ABD Program

All MCPs are included in the statewide P4P Pharmacy Carve-Out Incentive System. P4P rewards under the Pharmacy Carve-Out Incentive System include the at-risk amount included with the monthly premium payments (see Appendix F). The at-risk amount is calculated separately for each region that an MCP serves.

### 3.a.i. Determination Timeline

The regional-based statewide P4P Pharmacy Carve-Out Incentive determination is made semi-annually and calculated per the following timeline:

| Report Period | Months' Capitations Included in Pharmacy At-Risk Calculation | Month of Determination |
|---|---|---|
| April-June 2010 (Baseline) | Not Applicable | September 2010 |
| July-December 2010 | February 2010-December 2010 | March 2011 |
| January-June 2011 | January-June 2011 | September 2011 |

### 3.a.ii. Performance Measures and Standards

Performance is evaluated on the measures and standards listed below to determine the status of the pharmacy carve-out incentive at-risk amount. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

1. ABD Generic Pharmaceutical Penetration Rate (Appendix M, Section 4.c.ii.)

*Report Periods*: July-December, 2010, and January-June 2011. SFY 2012: TBD.

*Standard:* The Minimum Performance Standard established in Appendix M, *Performance Evaluation*

2. ABD Overall Pharmaceutical Utilization Rate (Appendix M, Section 4.c.i.)

*Report Periods*: July-December, 2010, and January-June 2011. SFY 2012: TBD.

*Standard:* The Minimum Performance Standard established in Appendix M, *Performance Evaluation*

**3.a.iii. Determining SFY 2011 P4P Pharmacy Carve-Out Incentives**

MCPs that meet the standard described in Section 3.a.ii.1. herein may retain one-third of the pharmacy carve-out incentive at-risk amount used in the SFY 2011 pharmacy carve-out determination for the appropriate semi-annual period. MCPs that meet the standard described in Section 3.a.ii.2. herein may retain two-thirds of the pharmacy carve-out incentive at-risk amount used in the SFY 2011 pharmacy carve-out determination for the appropriate semi-annual period.

MCPs that meet only one of the standards described in Section 3.a.ii. herein must return to ODJFS the remainder of its pharmacy carve-out incentive at-risk amount used in the SFY 2011 pharmacy carve-out determination for the appropriate semi-annual period. MCPs that meet neither of the standards described in Section 3.a.ii. herein will not be considered for the Pharmacy Carve-Out Incentives and must return to ODJFS one hundred percent of their pharmacy carve-out incentive at-risk amount used in the SFY 2011 pharmacy carve-out determination for the appropriate semi-annual period.

**4. P4P PHARMACY CARVE-OUT INCENTIVE SYSTEM - CFC PROGRAM**

**4.a. SFY 2011 CFC Program**

All MCPs are included in the statewide P4P Pharmacy Carve-Out Incentive System. P4P rewards under the Pharmacy Carve-Out Incentive System include the at-risk amount included with the monthly premium payments (see Appendix F). The at-risk amount is calculated separately for each region that an MCP serves.

**4.a.i. Determination Timeline**

The regional-based statewide P4P Pharmacy Carve-Out Incentive determination is made semi-annually and calculated per the following timeline:

| Report Period | Months' Capitations Included in Pharmacy At-Risk Calculation | Month of Determination |
|---|---|---|
| April-June 2010 (Baseline) | Not Applicable | September 2010 |
| July-December 2010 | February 2010-December 2010 | March 2011 |
| January-June 2011 | January-June 2011 | September 2011 |

**4.a.ii. Performance Measures and Standards**

Performance is evaluated on the measures and standards listed below to determine the status of the pharmacy carve-out incentive at-risk amount. A detailed description of the methodologies for each measure can be found on the *Medicaid Managed Care Program* page of the ODJFS website.

1. CFC Generic Pharmaceutical Penetration Rate (Appendix M, Section 4.c.ii.)

*Report Periods*: July-December 2010, and January-June 2011. SFY 2012: TBD.

*Standard:* The Minimum Performance Standard established in Appendix M, *Performance Evaluation*

2. CFC Overall Pharmaceutical Utilization Rate (Appendix M, Section 4.c.i.)

*Report Periods*: July-December, 2010, and January-June 2011. SFY 2012: TBD.

*Standard:* The Minimum Performance Standard established in Appendix M, *Performance Evaluation*

**4.a.iii. Determining SFY 2011 P4P Pharmacy Carve-Out Incentives**

MCPs that meet the standard described in Section 4.a.ii.1. herein may retain one-third of the pharmacy carve-out incentive at-risk amount used in the SFY 2011 pharmacy carve-out determination for the appropriate semi-annual period. MCPs that meet the standard described in Section 4.a.ii.2. herein may retain two-thirds of the pharmacy carve-out incentive at-risk amount used in the SFY 2011 pharmacy carve-out determination for the appropriate semi-annual period.

MCPs that meet only one of the standards described in Section 4.a.ii. herein must return to ODJFS the remainder of its pharmacy carve-out incentive at-risk amount used in the SFY 2011 pharmacy carve-out determination for the appropriate semi-annual period. MCPs that meet neither of the standards described in Section 4.a.ii. herein will not be considered for the Pharmacy Carve-Out Incentives and must return to ODJFS one hundred percent of their pharmacy carve-out incentive at-risk amount used in the SFY 2011 pharmacy carve-out determination for the appropriate semi-annual period.

**5. NOTES**

**5.a. Initiation of the At-Risk Amounts**

**5.a.i. ABD P4P Program**

The status of the at-risk amounts will not be determined for an MCP's first two contract years, because compliance with many of the standards in the ABD program cannot be determined

during this time period. In addition, MCPs in their first two contract years in the ABD program are not eligible for any additional P4P amount awarded for superior performance.

Applicable to P4P Through SFY 2010: Starting with the twenty-fifth month of regional membership in the Ohio Medicaid ABD Managed Care Program, an MCP's at-risk amounts will be included in the P4P systems. The determination of the status of these at-risk amounts will be made after at least two full calendar years of ABD regional membership, as many of the performance standards used in the ABD P4P systems require two full calendar years of ABD regional membership to determine an MCP's performance level. Because of this requirement, the number of months of at-risk dollars to be included in an MCP's first ABD at-risk status determinations may vary depending on when ABD regional membership starts relative to the calendar year.

Applicable to P4P Effective SFY 2011: Starting with the twenty-fifth month with Ohio Medicaid ABD Managed Care Program membership, an MCP's at-risk amounts will be included in the P4P systems. The determination of the status of these at-risk amounts will be made after at least two full calendar years of ABD membership, as many of the performance standards used in the ABD P4P systems require two full calendar years of ABD membership to determine an MCP's performance level.

**5.a.ii. CFC P4P Program**

The status of the at-risk amounts will not be determined for an MCP's first two contract years, because compliance with many of the standards in the CFC program cannot be determined during this time period. In addition, MCPs in their first two contract years in the CFC program are not eligible for any additional P4P amount awarded for superior performance.

Applicable to P4P Through SFY 2010: Starting with the twenty-fifth month of regional membership in the Ohio Medicaid CFC Managed Care Program, an MCP's at-risk amounts will be included in the P4P systems. The determination of the status of these at-risk amounts will be made after at least three full calendar years of CFC regional membership, as many of the performance standards used in the CFC P4P systems require three full calendar years of CFC regional membership to determine an MCP's performance level. Because of this requirement, more than twelve months of at-risk dollars may be included in an MCP's first CFC at-risk status determinations depending on when an MCP starts with the CFC program relative to the calendar year.

Applicable to P4P Effective SFY 2011: Starting with the twenty-fifth month with Ohio Medicaid CFC Managed Care Program membership, an MCP's at-risk amounts will be included in the P4P systems. The determination of the status of these at-risk amounts will be made after at least three full calendar years of CFC membership, as many of the performance standards used in the CFC P4P systems require three full calendar years of CFC membership to determine an MCP's performance level. Because of this requirement, more than twelve months of at-risk dollars may be included in an MCP's first CFC at-risk status determinations depending on when an MCP starts with the CFC program relative to the calendar year.

**5.b. Determination of At-Risk Amounts and Additional P4P Payments**

Given that unforeseen circumstances (e.g., revision or update of measure(s), applicable national standards, methods or benchmarks, or issues related to program implementation) may impact the determination of the status of an MCP's at-risk amounts and any additional P4P payments, ODJFS reserves the right to calculate an MCP's at-risk amounts (the status of which is determined in accordance with this appendix) using a lesser percentage than that established in Appendix F and to award any additional P4P in a lesser amount than that established in this appendix.

For MCPs that have participated in the Ohio Medicaid Managed Care Program long enough to calculate performance levels for all of the performance measures included in the P4P systems, determination of the status of an MCP's at-risk amounts may occur within six months of the end of the contract period. Where applicable, determination of additional P4P payments will be made at the same time the status of an MCP's at-risk amount, for the same P4P system, is determined. Given that unforeseen circumstances may impact the determination of the status of an MCP's at-risk amounts and any additional P4P payments, ODJFS reserves the right to revise the time frame in which the P4P System determinations will be made (i.e., the determinations may be made more than six months after the end of the contract period).

**5.c. Contract Termination, Nonrenewals, or Denials**

Upon termination, nonrenewal or denial of an MCP contract, the at-risk amounts paid to the MCP under the current provider agreement will be returned to ODJFS in accordance with Appendix P, *Terminations/Non-renewals/Amendments*, of the provider agreement.

Additionally, in accordance with Article XI of the provider agreement, the return of the at-risk amounts paid to the MCP under the current provider agreement will be a condition necessary for ODJFS' approval of a provider agreement assignment.

**5.d. Measures, Report Periods, and Data Sources**

The report period used in determining the MCP's performance levels varies for each measure depending on the frequency of the report and the data source. ODJFS reserves the right to revise P4P measures and report periods, as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's overall performance level for that contract period.

In accordance with Appendix N, Section K, effective SFY 2012, based on its review of an MCP's final HEDIS audit report (FAR) and any "Not Report" (i.e., NR) audit designations assigned, ODJFS reserves the right to not use the MCP's self-reported, audited HEDIS data to determine the status of an MCP's at-risk amount and any additional P4P payments for the P4P Incentive System determination established in this Appendix.

# APPENDIX P

## MCP TERMINATIONS/NONRENEWALS

Upon termination either by the MCP or ODJFS nonrenewal of an MCP's provider agreement, all previously collected refundable monetary sanctions will be retained by ODJFS.

### 1 . MCP-INITIATED TERMINATIONS/NONRENEWALS

If an MCP provides notice of the termination/nonrenewal of their provider agreement to ODJFS, pursuant to Article VIII of the agreement, the MCP will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

MCP agrees to fulfill all duties and obligations as required under Chapter 5101:3-26 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCP was under contract with ODJFS. Such duties and obligations include, but are not limited to, the submission by the MCP 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 MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODJFS until such time that the MCP 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 MCP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODJFS in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODJFS)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODJFS Fund account. In addition, the MCP 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, ODJFS will withhold the MCP's next month's capitation payment until such time that ODJFS receives documentation that the monetary assurance is received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCP 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 MCP's provider agreement, the monetary assurance will not be refunded to the MCP.

c. At-Risk Amount

The MCP must also return to ODJFS the at-risk amount paid to the MCP under the current provider agreement. The amount to be returned will be based on actual MCP membership for preceding months and estimated MCP membership through the end date of the contract. Any over payment will be determined by comparing actual to estimated MCP membership and will be returned to the MCP following the end date of the provider agreement.

The MCP must remit the at-risk amount in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODJFS)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the at-risk amount and obtain an invoice number prior to submitting the at-risk amount. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODJFS Fund account. In addition, the MCP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the at-risk amount is not received as specified above, ODJFS will withhold the MCP's next month's capitation payment until such time that ODJFS receives documentation that the at-risk amount is received by the Treasurer of State. Withholding a capitation payment by ODJFS does not waive the obligation of the MCP to return the at-risk amount.

d. Final Accounting of Amounts Outstanding

MCP must submit to ODJFS a final accounting list of any outstanding monies owed by ODJFS no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to MCP. ODJFS payment will be limited to only those amounts properly owed by ODJFS.

e. Data Files

In order to assist members with continuity of care, the MCP must create data files to be shared with each newly enrolling MCP. The data files will be provided in a consistent format specified by ODJFS and may include information on the following: case management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODJFS. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.

f. Notification

i. Provider Notification - The MCP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODJFS prior to distribution.

ii. Member Notification - The MCP must notify their members of the termination at least 45 days in advance of the effective date of termination. The member notification must be approved by ODJFS prior to distribution.

iii. Prior Authorization Re-Direction Notification - The MCP 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 MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCP must utilize ODJFS model language to create the notices and receive approval by ODJFS prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.

## 2. ODJFS-INITIATED TERMINATIONS

If ODJFS initiates the proposed termination, nonrenewal or amendment of an MCP's provider agreement pursuant to OAC rule 5101:3-26-10 and the MCP appeals that proposed action, the MCP's provider agreement will be extended through the issuance of an adjudication order in the MCP's appeal under the ORC Chapter 119.

During this time, the MCP 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 MCP exceeds 69 points, each subsequent point accrual will result in a $15,000 nonrefundable fine.

Pursuant to OAC rule 5101:3-26-10(H), if ODJFS has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODJFS may notify the MCP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCP without cause. If ODJFS has proposed the termination, nonrenewal, denial or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODJFS may propose to terminate the membership of all of the MCP's members. The appeal process for reconsideration of the proposed termination of members is as follows:

- All notifications of such a proposed MCP membership termination will be made by ODJFS via certified or overnight mail to the identified MCP Contact.

- MCPs notified by ODJFS of such a proposed MCP 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 Deputy Director, Office of Ohio Health Plans, and received by 3PM Eastern Time on the third working day following receipt of the ODJFS notification of termination. The address and fax number to be used in making these requests will be specified in the ODJFS notification of termination document.

- The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests must explain in detail why the proposed MCP membership termination is not justified. The MCP’s justification for reconsideration will be limited to a review of the written material submitted by the MCP.

- A final decision or request for additional information will be made by the Deputy Director within three working days of receipt of the request for reconsideration. Should the Deputy Director require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.

- The proposed MCP membership termination will not occur while an appeal is under review and pending the Deputy Director’s decision. If the Deputy Director denies the appeal, the MCP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODJFS determines that it would be in the best interest of the members.