Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of *Ohio* enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.*ii.* below), or who meet certain categories of "special needs" beneficiaries (see D.2.*iii.* - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(*i*)
1932(a)(1)(B)(*ii*)
42 CFR 438.50(b)(1)

1. The State will contract with an

_X_ *i.* MCO
___ *ii.* PCCM (including capitated PCCMs that qualify as PAHPs)
___ *iii.* Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method in the contracting entity will be:

___ *i.* fee for service;
_X_ *ii.* capitation;
___ *iii.* a case management fee;
_X_ *iv.* a bonus/incentive payment;
___ v. a supplemental payment, or
___ vi. other. (Please provide a description below).

The MCO rate methodology is outlined in the MCO provider agreement. attached document. The attached spreadsheets are the different appendices which are referenced in the methodology sheets are attached to this document

1905(t)
42 CFR 440.168

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's

Citation		Condition or Requirement
42 CFR 438.6(c)(5)(iii)(iv)		case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on interguvernmental transfer agreements. ____vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4.	Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* ~~*This purpose of this SPA amendment is to update the SPA so as to reflect Ohio's regional approach for statewide mandatory enrollment.*~~ *The Ohio Department of Job and Family Services (ODJFS) will continue to convene community-based meetings of key stakeholders to assure ongoing public involvement under the SPA. Stakeholders attending these meetings include local providers, consumer advocates, MCOs, county departments of job and family services, local health departments, and other social service agencies.* *The statewide Medical Care Advisory Committee has served as a forum for discussion of the managed care program and related issues.* *In addition to these ongoing groups, ODJFS has convened ad hoc "roundtables" for the discussion of specific issues such as dental access, the*

Citation	Condition or Requirement
	prudent layperson standard, and the implementation of the Balanced Budget Act. Depending on the topic, attendees of these meetings are associations and managed care organizations with the goals of sharing concerns and identifying best practices.
	Other forums for stakeholder involvement include meetings with the Ohio Department of Health, Bureau of Children with Medical Handicaps; meetings with provider associations, and technical assistance sessions with MCOs and county departments of job and family services.
1932(a)(1)(A)	5. The state plan program will X will not __ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory __ / voluntary __ enrollment will be implemented in the following county/area(s): _____
	i. county/counties (mandatory) _____
	ii. county/counties (voluntary) _____
	iii. area/areas (mandatory) _____
	iv. area/areas (voluntary) _____
	C. State Assurances and Compliance with the Statute and Regulations.
	If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. __X__ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ____ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met
1932(a)(1)(A)	3. __X__ The state assures that all the applicable requirements of section 1932

Citation		Condition or Requirement
42 CFR 438.50(c)(3)		(including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4.	X The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	X The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	X The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	X The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis.

The following groups are enrolled on a mandatory basis in selected service areas.
** Section 1931 Children and Adults and related poverty level populations, including pregnant women and children (TANF/AFDC)*
** Title XXI CHIP children*
** Aged, blind, or disabled (ABD) individuals as described in division (A)(2) of section 5111.01 of the Ohio Revised Code except for those individuals who are dually eligible under both the medicaid and medicare programs as well as those individuals who are:*

i. Under twenty-one years of age;

ii. Institutionalized;

Citation	Condition or Requirement

iii. Eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements; or

iv. Individuals receiving medicaid services through a ntedicaid waiver component, as defined in section 5111.85 of the Ohio Revised Code.

~~* Indians who are members of Federally recognized tribes, except as permitted under 42 C.F.R 438.50(d)(2) have the option to enroll.~~

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment in any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who became Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. X Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act, or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. X Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. ___ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

1932(a)(2)(A)(v)
42 CFR 438.50(3)(iii)

v. X Children under the age of 19 years who are in foster care or other out-of-the-home placement.

Citation	Condition or Requirement
1932(a)(2)(A)(*iv*) 42 CFR 438.50(3)(iv)	vi. _X_ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(*ii*) 42 CFR 438.50(3)(v)	*vii.* _X_ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

These are children served through the Ohio Department of Health, Bureau of Children with Medical Handicaps (BCMH). BCMH administers Ohio's Title V program.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

_X_ *i.* program participation,
___ *ii.* special health care needs, or
___ *iii.* both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

_X_ *i.* yes
___ *ii.* no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI;

Eligibility database and self-identification.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

Citation	Condition or Requirement

Eligibility database and self-identification.

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

Eligibility database and self-identification.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Eligibility database and self-identification

1932(a)(2)
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

Although under our current system we are unable to identify all special needs children prior to their receiving a notice informing them of their need to enroll, exempted groups identified by the ~~selection services contractor~~ Managed Care Enrollment Center (MCEC) ~~(enrollment broker)~~ during the enrollment interview will be advised of their option not to enroll in a plan.

Further, we will make ongoing efforts to notify exempted groups that, if they are enrolled in a plan and do not wish to remain enrolled, they can disenroll from the MCO and receive their health care benefit through the traditional Medicaid fee-for-service (FFS) program. First, language has been added to the MCO Consumer Guide specific to the enrollment options for children in exempted groups. The Consumer Guide is distributed prior to the annual open enrollment month in each service area ~~county~~ and provided to consumers throughout the year by Ohio's enrollment broker (MCEC). Second, all MCOs in mandatory enrollment counties are required to include a notice in their new member letter along with the member handbook and provider directory. This new member letter details the population groups that are not required to enroll in an MCO and what action to take if they believe they meet this criteria and do not wish to be enrolled in an MCO. Finally, MCOs are required to periodically provide general information on children with special needs enrollment options through their member handbooks, newsletters, etc.

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

Citation	Condition or Requirement

i. Recipients who are also eligible for Medicare.

Recipients who are also eligible for Medicare will be identified based on their eligibility category in the state eligibility system

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. Indians who are members of Federally recogoized Tribes will need to self-identify.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

- ~~*Recipients who are homeless.*~~
- *ABD exempt individuals – See response to D.1.*

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

H. Enrollment process.

Ohio is committed to statewide mandatory managed care enrollment. However, in service areas with fewer than two MCOs, enrollment may occur on either a voluntary or preferred option basis. In service areas with two or more MCOs, enrollment in managed care is mandatory. ODJFS requested and received approval from CMS to operate a preferred option program in selected Ohio service areas served by only one MCO. Eligible consumers in preferred option service areas choose between FFS and the MCO. Consumers who do not actively choose the FFS option are enrolled in the MCO. Enrollees in preferred option service areas are able to disenroll without cause at any time and choose the FFS option. There are no open enrollment or lock-in restrictions in preferred option service areas.

1932(a)(4)
42 CFR 438.50

I. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient

Citation	Condition or Requirement

during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.*i*).

The default enrollment process is made based on the goal of preserving the existing provider-patient relationship. In order to ensure continuity of care, previously MCO-enrolled recipients are returned to the same MCO, except if the disenrollment was recipient initiated. For members not previously enrolled, Medicaid FFS paid claims having primary care service codes are extracted for each MCO eligible and used to determine the most recent and regular primary care visit. The member is then assigned to the MCO that has this provider on their panel.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.*ii*).

ODJFS contracts with MCOs, not providers directly. We attribute part of the success of the managed care program to the fact that MCOs include the traditional FFS providers in their panel, as well as other providers that do not participate in the FFS system. Also, we require MCOs to either contract with all Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) in the service area or allow their members open access to any non-contracting FQHC or RHC.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Citation	Condition or Requirement
	~~If the consumer fails to choose an MCO within two months after receiving enrollment materials from the State, the State will assign the recipient to an MCO.~~ For those consumers who were not previously enrolled in an MCO or where it is not possible to determine any prior patient/provider relationship, the consumer will be automatically assigned to an MCO based on a round robin methodology, the MCO's enrollment thresholds as well as their ability to meet performance standards.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:
	i. The state will _X_ /will not____ use a lock-in for managed care.
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be *one month at a minimum*.
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*
	~~*Selection services contractor*~~ *MCEC (enrollment broker) written notification.*
	iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*
	- *MCEC (enrollment broker) provides written notification advising consumers of their right to disenroll without cause the first 90 days of their enrollment.* - ~~*Consumer contact record, i.e. MCO enrollment verification.*~~ - ~~*MCO new member packet.*~~ - *MCO member handbook.* - *Consumer Guide* - *Mandatory enrollment notice* - *Open enrollment notice*
	v. Describe the default assignment algorithm used for auto-assignment.

Citation | Condition or Requirement

(Examples: ratio of plans in a geographic service area to guaranteed enrollees, usage of quality indicators)

As described in H.2.i, the default assignment algorithm is based first on the goal of preserving the existing provider-patient relationships. When necessary however, such as when the Medicaid recipient does not have an existing relationship with their historical provider, the individual may be assigned to an MCO based on a round robin methodology, the MCO's enrollment thresholds as well as their ability to meet performance standards. This process is described in H.2.iii.

vi Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Assignment rates are reviewed monthly.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

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

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

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

In mandatory service areas

3 ___ The state plan program applies the rural exception to choice requirements at 42 CFR 438.52(a) for MCOs and PCCMs.

___ This provision is not applicable to this 1932 State Plan Attendment.

4 ___ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of

Citation	Condition or Requirement
1932(a)(1)(A)	the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.) _X_ This provision is not applicable to this 1932 State Plan Amendment. 5. _X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. ___This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR 438.50	J. Disenrollment 1. The state will _X_ /will not___ use lock-in for managed care. 2. The lock-in will apply for *up to 12* months (up to 12 months). 3. Place a check mark to affirm state compliance. _X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c). 4. Describe any additional circumstances of "cause" for disenrollment (if any). *Per Ohio Administrative Code rules, membership termination for just cause, includes a situation, as determined by ODJFS, in which continued membership in the MCO would be harmful to the interests of the member.*
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM) *Details regarding MCO service exclusions, limitations and clarifications are outlined in Ohio Administrative Code and the MCO's provider agreement with the state*

Citation	Condition or Requirement

~~Effective February 1, 2010, pharmacy benefits (specified prescribed drugs and certain medical supplies) for MCO enrollees were removed from the risk-based managed care program and placed under the Medicaid fee-for-service delivery system. MCO enrollees will access the carved-out pharmacy benefits through the Medicaid fee-for-service delivery system. Pharmaceuticals administered in certain provider settings will continue to be provided by MCOs.~~

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will _X_ /will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _X_ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option.

(Example: a limited number of providers and/or enrollees.)ODJFS may limit the number of entities it contracts with for a specific service area if we already contract with a sufficient number of MCOs to require mandatory enrollment for eligible consumers and sufficient access to participating providers is assured. We do not expect to have a large number of entities that are able to meet our specified provider panel requirements for each service area as the key health care providers have indicated that they are unlikely to contract with more MCOs than they believe the market can realistically sustain. ODJFS would give strong consideration to adding an additional MCO if they would bring services or providers not currently available to MCO members in a particular service area.

4. ___ The selective contracting provision is not applicable to this state plan.