

The Ohio Department of Medicaid Managed Care Quality Strategy

The Ohio Department of Medicaid Office of Health
Innovation and Quality

2018

Executive Summary

In its continued effort to reform and modernize the Medicaid program, the Ohio Department of Medicaid's (ODM's) quality strategy prioritizes paying for the value of care provided to our covered populations, driving improved population health, and striving for health equity. These priorities reflect the three aims of the National Quality Strategy: better care, healthy people/healthy communities, and smarter spending. The more traditional tenants of safety, person- and family-centered care, evidence-based practices, coordination of care and administrative efficiencies serve as pillars to support improved outcomes for specific populations as opposed to stand-alone initiatives.

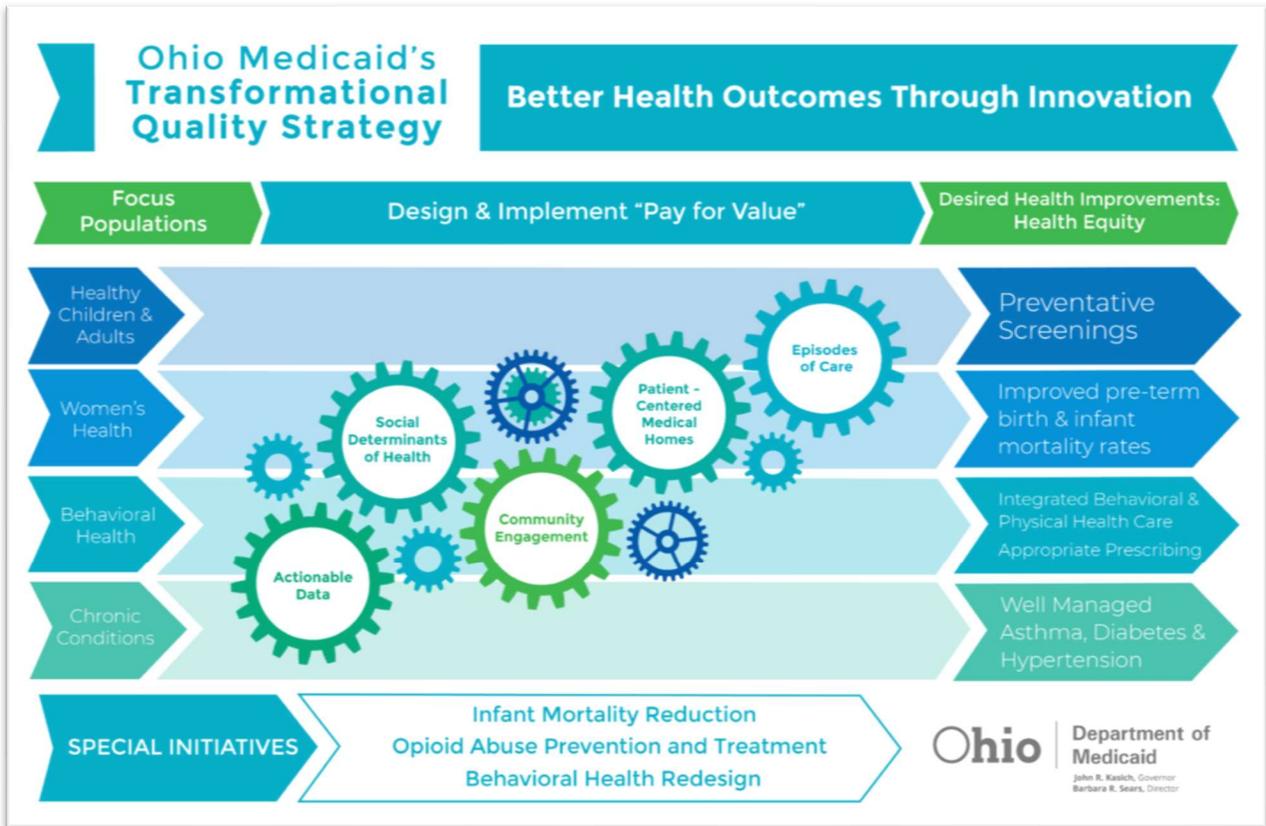
As traditional eligibility categories do not necessarily align with the variation and complexity of health solutions required at the person level, five population "streams" have been identified to structure the development of effective initiatives for population health management. These are:

- Women's health (including those who are pregnant)
- Individuals with chronic conditions such as cardiovascular disease and diabetes,
- Individuals with primary behavioral health conditions,
- Healthy children and,
- Healthy adults¹.

Initiatives have been designed with attention to scale across the entire state, harnessing transparent, timely and actionable data, evidence-based practices, community engagement and more comprehensive and widespread value-based purchasing efforts in the form of patient centered medical homes and episodes of care. Our goal is to improve population health outcomes by having all Medicaid recipients participate in the redesigned health care delivery system, increasing preventative screens and appropriate care, addressing priority population health issues such as decreasing racial disparities in preterm birth and infant mortality rates, integrating behavioral and physical health care, optimally managing chronic conditions, and addressing social determinants of health as appropriate.

The graphic below depicts the core components of our view of ODM's quality strategy realizing that safety, person-centeredness, best-evidenced practice, coordination and efficiencies are built into each of the specific strategies. Desired improvements in health equity are in the top, right-hand corner of the diagram below to emphasize that our efforts are all driving towards this prioritized outcome. Such a strategy cannot be undertaken without strong and consistent leadership, as well as common tools and processes such as those frequently used in quality improvement science methodologies which integrate proximate data for faster, informed decision-making at multiple levels.

¹ Healthy children and adults are grouped together in the graphic to emphasize the importance of coordinated efforts to increase the use of preventative health care.



This document provides a summary of ODM's Managed Care Quality Strategy. To ensure comprehensiveness and facilitate review, the document is organized to align, when possible, with the Centers for Medicare and Medicaid Services' (CMS') Quality Strategy Toolkit for the States, and includes the following sections: Introduction, Assessment, State Standards, Delivery System Reform, Improvements and Interventions, and Conclusions and Opportunities. In addition, the document has several appendices, which aim to provide additional clarity on the course of quality improvement efforts within the Ohio Medicaid managed care program.

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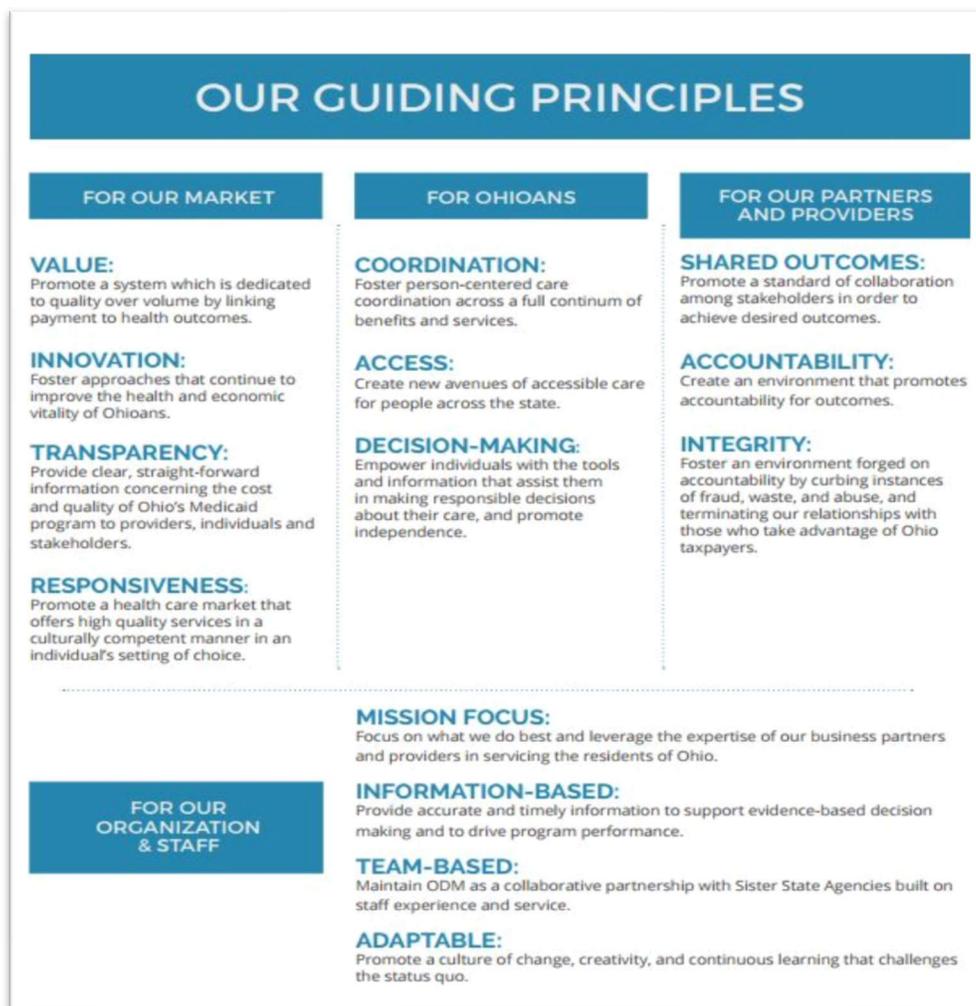
I. Introduction

The Ohio Department of Medicaid is continually striving to improve the quality of healthcare and health outcomes for the individuals we cover. This is articulated within the ODM Mission and Vision Statements as well as within ODM’s Guiding Principles.

ODM Mission: Providing accessible and cost-effective health care coverage for Ohioans by promoting personal responsibility and choice through transformative and coordinated quality care.

ODM Vision: We are dedicated to being a national leader in health care coverage innovation that improves the lives of Ohioans and strengthens families.

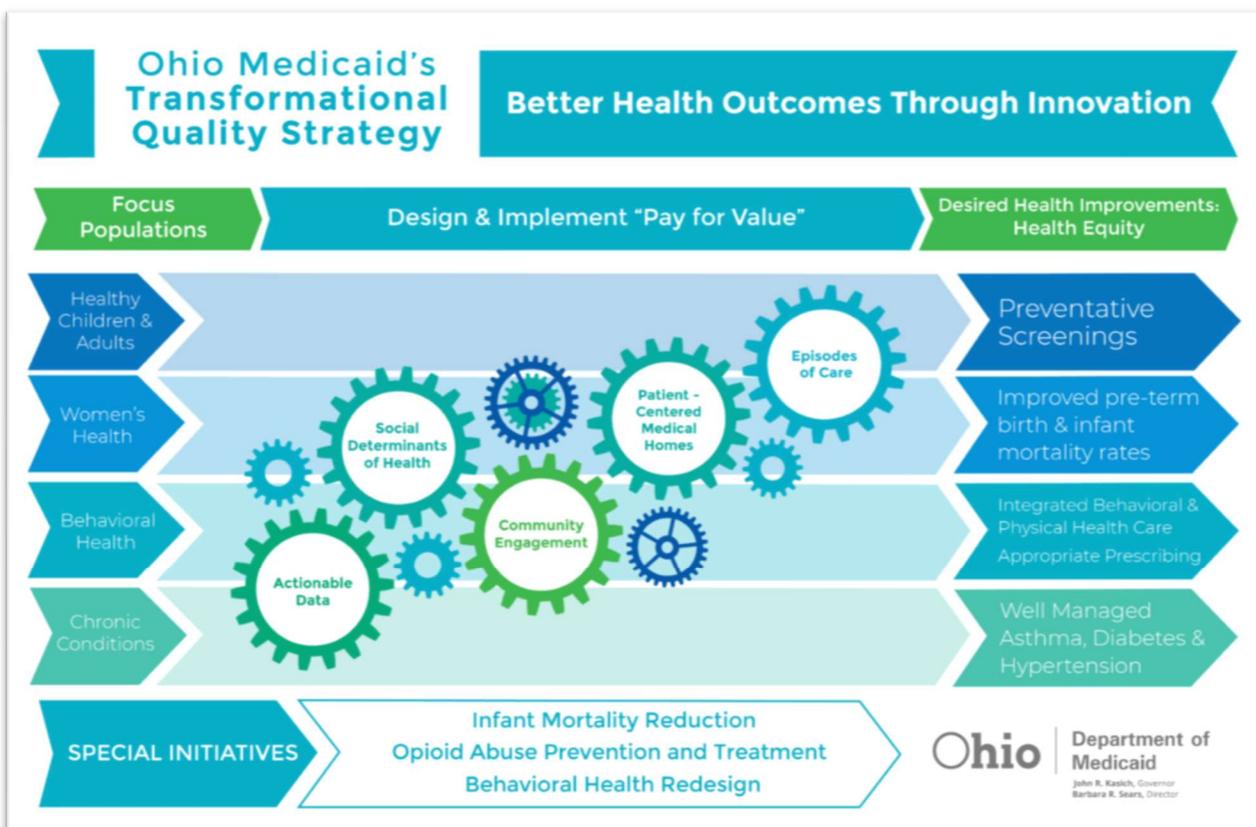
Figure 1. Medicaid Guiding Principles



The Ohio Department of Medicaid’s Quality Strategy, which aligns with the CMS Quality Strategy and the broader aims of the National Quality Strategy, puts these guiding principles into motion by actively using

data to facilitate initiatives aimed at paying for value rather than volume, engaging communities, and addressing social determinants of health in order to improve health across our population streams to pursue the outcomes of preventing disease through early detection, reducing preterm birth and infant mortality, integrating physical and behavioral health, and optimally managing chronic conditions.

Figure 2. Medicaid Quality Strategy



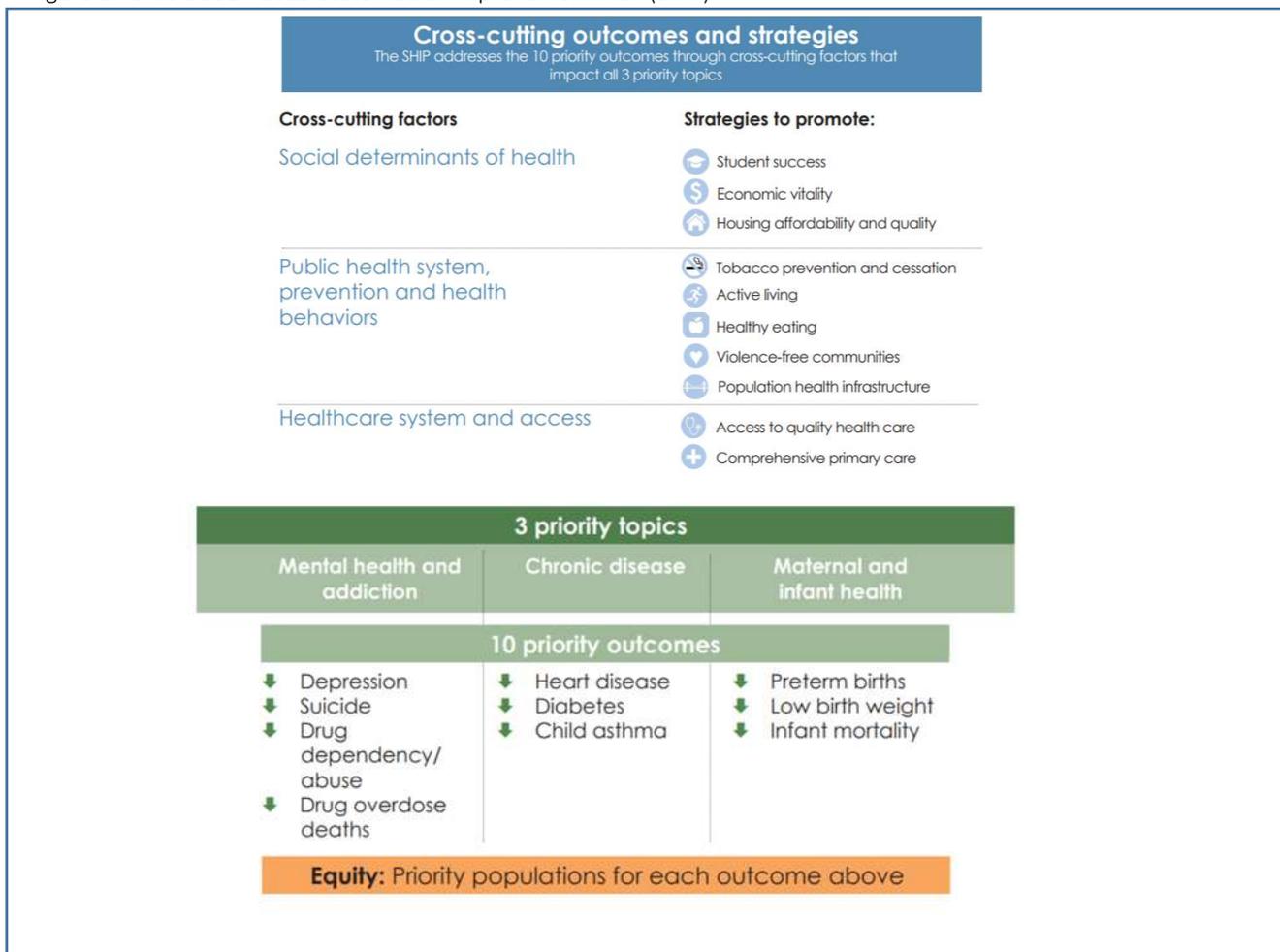
Managed care plans are central to improving population health outcomes within each of these streams and are therefore required to participate in ODM's efforts to improve the health and quality of care for the Ohio Medicaid population.

ODM has created a robust accountability system to ensure that MCPs are working within the framework of the Quality Strategy to assess and improve the quality of care provided to individuals insured by Medicaid. Accountability mechanisms are as diverse as contracting language, ODM policy, payment mechanisms, guidance documents, performance measure based incentives, report cards, dashboards, and ODM-initiated improvement projects. Analytical and technical assistance provide direction and support to facilitate improvement.

Strategic partnerships with provider and provider associations, private insurers, other state agencies, academic medical centers, and state quality collaborative organizations also contribute to success by ensuring coordinated planning and facilitating alignment across complimentary initiatives.

These collaborative partnerships are strengthened by the alignment of the Medicaid State Quality Strategy with the State Health Improvement Plan (Figure 3). Ohio’s quality strategy was developed in tandem with the State Health Improvement Plan (SHIP). The alignment between ODM’s quality strategy and the SHIP allows ODM and its contracted managed care plans to more effectively collaborate with other state agencies on improvement goals.

Figure 3. Ohio’s 2017-2019 State Health Improvement Plan (SHIP)



Managed Care Goals and Objectives and Overview

Brief History of Ohio’s Managed Care Program

The Ohio Medicaid Managed Care Program was initiated in 1978 in an effort to improve access, quality, and continuity of care, while reducing the growth of Medicaid spending. An alternative to fee-for-service (FFS) delivery, managed care utilizes risk-based contracts with licensed managed care plans (MCPs) to provide healthcare services to Medicaid individuals. Although initially operated as a Medicaid state

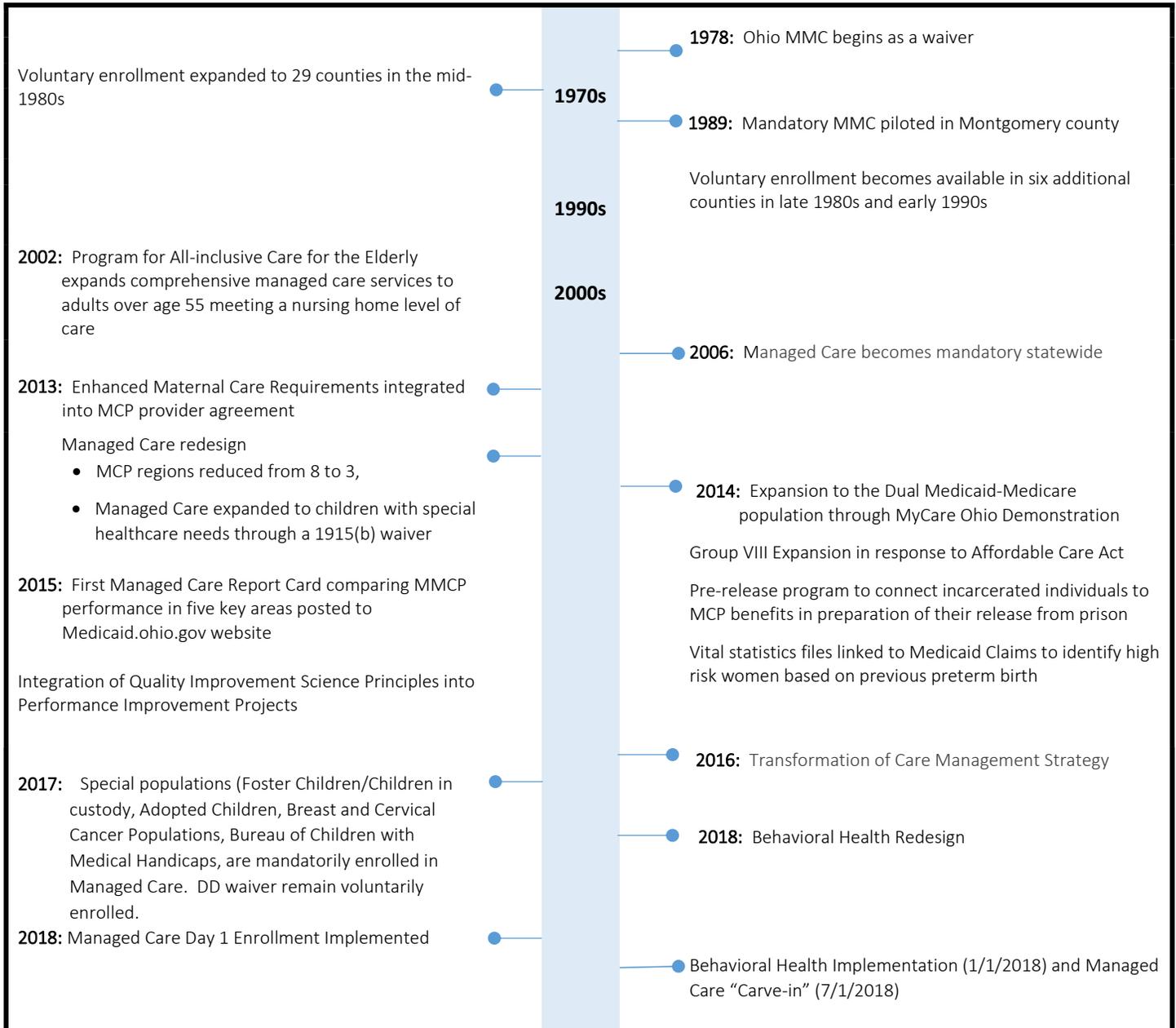
waiver, beginning July 1, 2005, CMS permitted Ohio to operate the program under the authority of a State Plan Amendment. In 2006, Ohio's Medicaid Managed Care Program was expanded to all 88 Ohio counties.

ODM announced its intention to redesign the Medicaid Managed Care Program in January 2012. Changes to the program reduced the state's eight administrative service regions to three, combined coverage for the Covered Families and Children (CFC) and Aged, Blind, and Disabled (ABD) populations, covered a portion of children with special needs, required MCPs to meet higher standards on national performance measures to receive financial incentives, and required MCPs to develop provider incentives aimed at improving quality of care and health outcomes. Five MCPs were selected and began providing services in all three regions in July of 2013. This redesign has simplified program administration, encouraged market stability, and offered individuals more choice.

In January 2014, ODM expanded Medicaid coverage to individuals making up to 138 percent of the federal poverty level (Group VIII). Many of these individuals are childless adults living in poverty and most receive their Medicaid coverage through an MCP. In any given month during state fiscal year 2018, Ohio's five managed care plans provided services to an average of 2.4 million Ohioans, nearly eighty-seven percent of all individuals enrolled in Medicaid.

In May of 2014, dually eligible individuals in 29 counties began enrolling in Managed Care through the MyCare Ohio, Ohio's integrated care delivery system for Ohioans who receive both Medicaid and Medicare benefits. This marked the first time that Medicaid recipients with a nursing facility-based level of care were eligible for the benefits of comprehensive care management. In any given month during state fiscal year 2018, an average of 109,000 individuals were enrolled in the MyCare Ohio plan (MCOP).

Figure 4. Timeline of ODM’s Managed Care History



Overview of Quality Management Structure

External Quality Management Structure

Medicaid has a number of external partners that contribute to the structure and success of ODM’s managed care quality strategy. Each of these is described below and shown in Figure 5.

External Quality Review Organization (EQRO): Based on federal regulations, states that operate Medicaid Managed Care Programs are required to arrange for an independent EQRO to conduct annual reviews of the quality, accessibility, and timeliness of services provided to Medicaid individuals by health plans.

Managed Care Plans (MCP): ODM's quality management strategy is informed through MCP performance metric reporting, MCP Family Advisory council input, monitoring of access and utilization, sharing of individual enrollee concerns and grievances, and providing Quality Assessment and Performance Improvement (QAPI) program reports. MCPs support Medicaid's quality structure by: conducting improvement projects across their Medicaid managed care and/or MyCare Ohio populations, developing health and wellness programs, performing care coordination activities, supporting community-based initiatives and assessing their quality measurement and improvement strategies. ODM requires that both the Quality Improvement Director and Medical Director, as well as key staff involved in improvement projects have training in quality improvement science standards and methods.

Additional Quality Partners: Ohio's Managed Care Quality Strategy is also influenced by other entities. These include the Medical Care Advisory Committee (MCAC), provider associations (e.g. Ohio Association of Health Plans), other State agencies (e.g. Ohio Department of Mental Health and Addiction Services, Ohio Department of Health), the Ohio Commission on Minority Health, legislative committees (e.g. Joint Medicaid Oversight Committee), State quality collaborative organizations (e.g. Ohio Perinatal Quality Collaborative), academic medical centers, and national organizations (e.g. NCQA).

Development and Review of Ohio's Quality Strategy

Although the quality strategy is formally reviewed and updated at least once every three years, ODM also updates the strategy whenever a significant change is made. Significant change in this context means a change in benefit design or content, population coverage, or structure of ODM delivery system.

The managed care quality strategy and related initiatives are formally evaluated through review of the EQRO technical report recommendations, assessing state and MCP performance on HEDIS measures, reviewing MCP evaluations of their quality programs in their QAPI submissions, and examining the results of provider and member satisfaction surveys. In addition stakeholder, provider, and member feedback received through MCP family advisory councils, consumer grievances and complaints, improvement projects, and the public comment process for updates to Ohio Administrative code all influence ongoing assessment of the strategy.

Once the quality strategy is updated based upon this assessment, a draft is made available for public comment and presented to the Medical Advisory Committee for input, the strategy is then further refined to incorporate the results of this public comment period. This refined draft is then posted to ODM's website submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. Once approved by CMS, ODM posts the final quality strategy on the ODM website.

ODM obtains ongoing public comment on the quality strategy and related initiatives through presentations to such groups as, stakeholder organizations, sister agencies, the Governor's Office of Health Transformation (OHT), the Medical Care Advisory Committee, Ohio Medicaid's contracted MCPs,

and professional organizations. In addition, formal public comment processes for ODM policy changes provide opportunities for all Ohioans to add value to ODM’s efforts to promote value-based population health. Figure 6 maps out the process of continual quality strategy assessment, development and review.

The ongoing nature of review and modification allows the quality strategy to remain relevant and align with MMC and MCOP contractual requirements, QAPI submissions, and EQRO assessments and recommendations.

Figure 5. ODM’s Managed Care Program’s Quality Structure

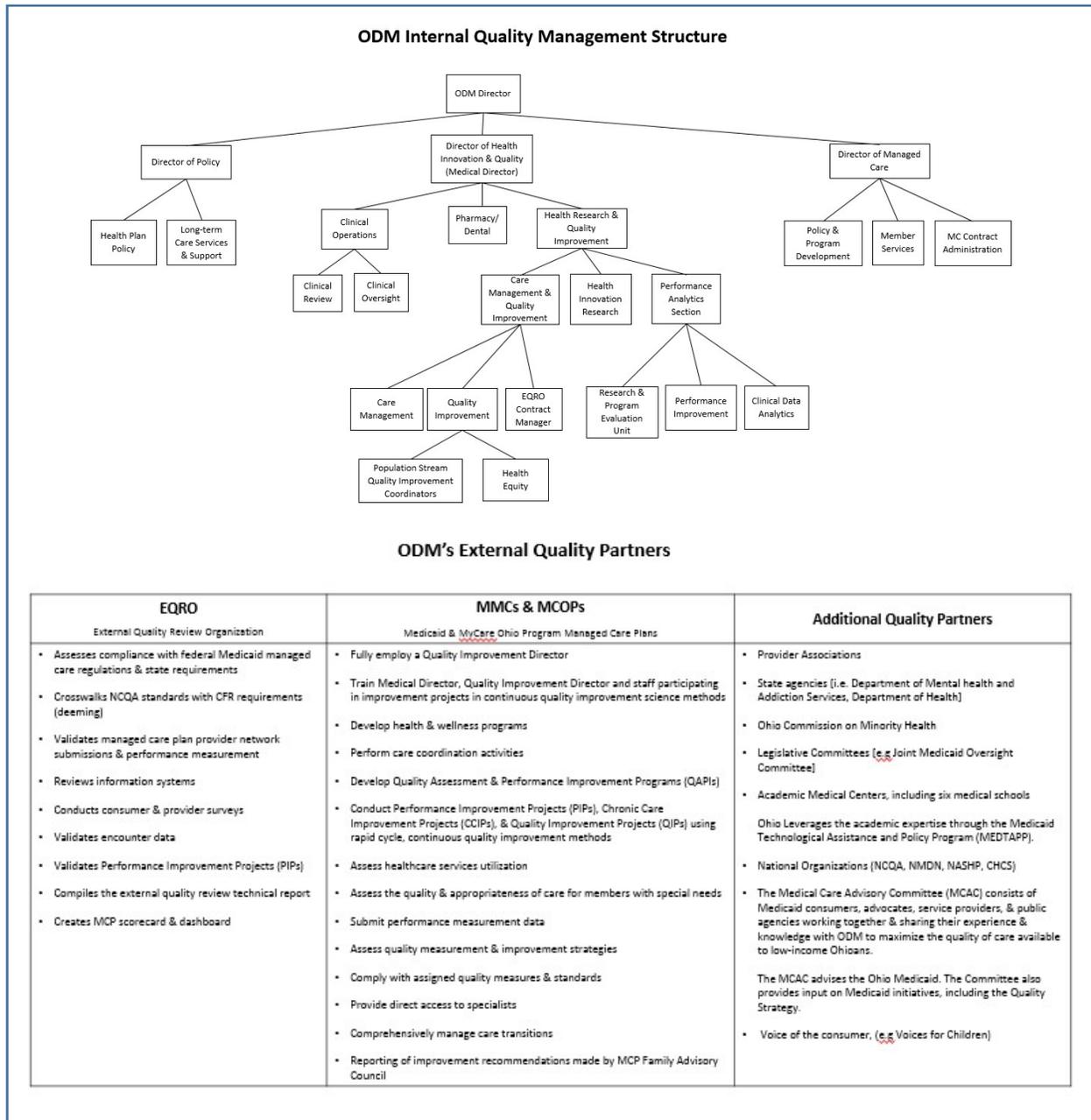
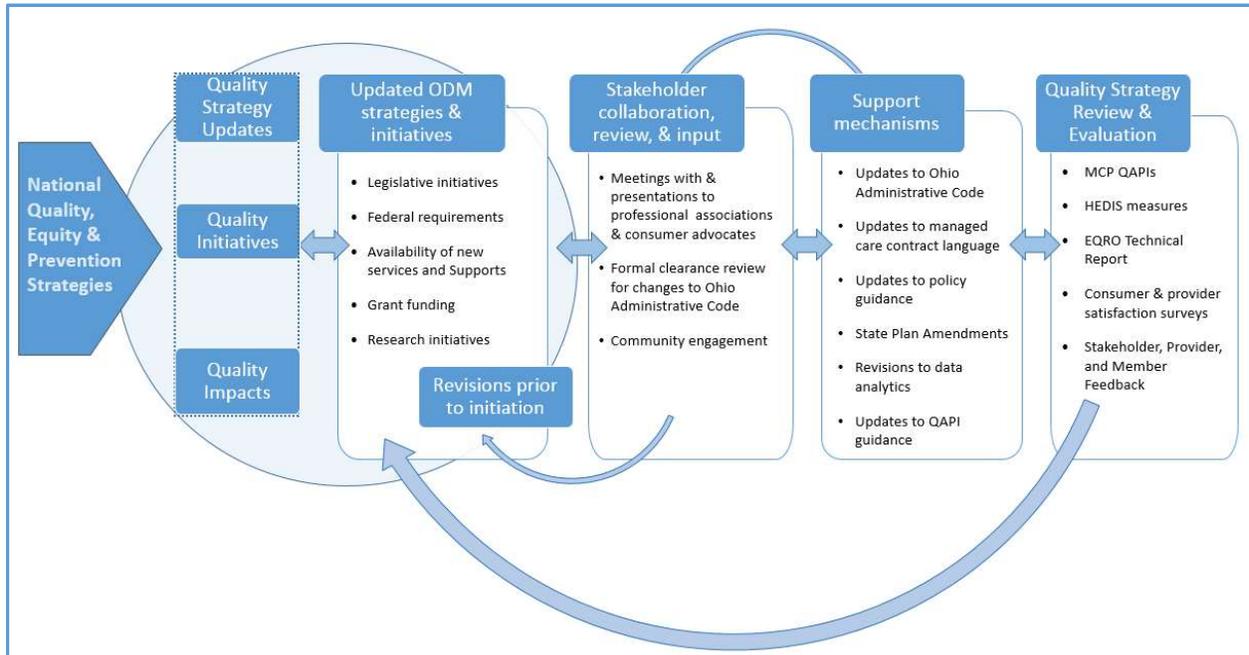


Figure 6. Development and Review of the Managed Care Quality Strategy



Ohio's Decision to Leverage Managed Care Plans for Better Outcomes

The managed care delivery model has resulted in reductions in overall costs, increased accountability and improved quality of care to individuals insured by Medicaid. This is due, in part, to the ability of managed care to offer many value-added benefits not available to individuals through the FFS delivery system, including:

- Targeted Improvement efforts related to state priority areas (e.g., the Progesterone improvement project aimed at reducing preterm births, support of community-based improvement efforts);
- Preventative care and care coordination services within a medical home setting;
- Advice and direction for medical issues via a toll-free nurse line available 24 hours per day, seven days a week;
- Assistance in accessing services through the provision of a dedicated call center for members and a provider directory listing primary care providers (PCPs), hospitals, and specialists;
- Special services, such as comprehensive care management, with a tiered structure based on risk status;

- Assistance to members with navigating the healthcare system via a member services call center, preventive healthcare programs, education materials and member incentives to promote appropriate healthcare utilization;
- Expanded benefits—transportation, vision, and dental;
- Expanded provider networks;
- Additional opportunities to hear the consumer’s perspective (e.g., focus groups, satisfaction surveys, MCP family advisory councils); and

Managed Care Program Goals and Objectives

ODM’s Quality Strategy focuses on providing the highest quality, cost-effective care in the context of an optimal healthcare experience for a population of patients. This translates into the following strategic goals:

- Continuously improving population health and healthcare quality,
- Promoting value over volume, and
- Achieving health equity.

These goals are addressed across the populations served by Medicaid – women’s health, individuals with behavioral health needs, individuals with chronic conditions, and healthy children and adults -- in order to achieve the outcomes of enhanced prevention and detection through increased preventative screening, reductions in preterm birth and infant mortality rates, integrated behavioral and physical health care (including appropriate prescribing) and well-managed chronic conditions such as asthma, diabetes and hypertension.

ODM’s quality strategy focuses on incorporating best practices and transforming its systems in an effort to improve quality, experience, and cost outcomes. This includes using continuous quality improvement methods such as process mapping, key driver diagrams, and plan-do-study-act cycles to streamline workflow and remove administrative barriers across the care continuum; assessing and incorporating the voice and the experience of our high-risk communities through community engagement and collaboration; promoting value-based initiatives such as episode-based payment and the comprehensive primary care model for coordinating care; redesigning behavioral health to better coordinate across payers, expand treatment options and support parity; redesigning the care management system; and producing actionable and timely data for decision making. For more information about ODM’s current and future initiatives, see Sections IV-VI.

ODM provides MCPs with the opportunity to review and comment on the managed care policy and operational changes prior to implementation, provides regular opportunities for MCPs to receive program updates and discuss program issues with ODM staff, and incorporates stakeholder input into the design of new initiatives supporting the quality strategy. Each of these ongoing activities results in public and stakeholder review at both the initiative and supporting policy level and leads to greater agility and efficiency in the initiative design and implementation that support quality strategy goals. Prior to submitting the quality strategy to CMS, ODM reviews the strategy with its MCAC, provides opportunities for input via formal in-person meetings and webinars, and otherwise makes the strategy available for public comment.

As required by 42 CFR 438.340, the final ODM Managed Care Quality Strategy is made available on ODM's public website.

II: Assessment

Quality and Appropriateness of Care

State procedures for assessing quality and appropriateness of care

Methods for assessing both the quality and appropriateness of care are key for measuring ODM's progress toward its goals and desired outcomes. Methods include the establishment of performance measure standards and the monitoring of MCP performance in relation to those standards, regular assessment of MMC and MCOP contract compliance, external quality reviews, assessments of consumer needs, surveys of consumer and provider satisfaction, assessment of access to care, utilization reviews, and analysis of complaints and appeals. Additionally, each MCP is required to have internal mechanisms in place to assess the quality and appropriateness of care. These mechanisms are specified in the MCPs annual QAPI submission to ODM (see Appendix C of this submission). ODM regularly provides information to MCPs regarding different aspects of their performance including: information on MCP-specific and statewide external quality review organization surveys and consumer satisfaction surveys. MCPs are able to see how their performance compares to national benchmarks and to each other.

ODM's contracted External Quality Review Organization (EQRO), Health Services Advisory Group conducts additional activities that enhance assessment of quality of care and access. These services include, but are not limited to:

- **Encounter Data Accuracy Studies:** The EQRO is responsible for completing encounter data accuracy studies. The first study is a delivery payment study to verify the accuracy of MCP encounter data submissions. The second study compares the accuracy and completeness of payment data stored in the MCP's claims system to payment data submitted to and accepted by ODM.
- Administration of provider and consumer satisfaction surveys
- Validation of MCP performance measures
- Administrative Reviews of MCP compliance with state and federal regulations.
- **Technical Assistance:** ODM relies upon the national expertise of the EQRO vendor to provide technical assistance to both the State and the MCPs in order to maximize efficiency and effectiveness in the administration of the managed care program. This includes, but is not limited to, the design and implementation of the performance improvement projects and identification of best clinical and administrative practices.
- **Validation of Performance Improvement Projects:** The EQRO validates the content of five (5) Modules which align with EQR Protocol 3 ("Validating Performance Improvement Projects") and the Model for Improvement², popularized by the Institute for Healthcare Improvement (IHI).

Methods for identifying age, race, ethnicity, sex, primary language, and disability status

ODM requires MCPs to use demographic information to promote culturally competent service delivery and to progress toward the goal of reducing health disparities. This includes efforts to ensure that

² Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

provider networks are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender, and other unique needs of the managed care population.

Demographic data that includes age, race, ethnicity, sex, primary language, and disability status are collected at the point of eligibility determination and enrollment and shared with the MCPs and the Managed Care Enrollment Center. (“Disability status” in this context means whether the individual qualified for Medicaid on the basis of a disability.) However, applicants are not strictly required to provide elements of this information when enrolling for benefits since it is not necessary for eligibility determination. Consequently, approximately 25% of applicants do not include this information, making analyses and efforts to reduce disparities difficult. Given the voluntary nature of race data collected through eligibility systems, ODM is working with its contracted MCPs to actively pursuing avenues for improving the completeness and usefulness of State demographic data, including augmenting this data with practice-level data collected through improvement projects.

MCPs are contractually obligated to deliver services in a culturally competent manner to all members, including those with Limited English Proficiency (LEP). If a common primary language other than English is identified as being prevalent in the MCP’s service area, the MCP is required to translate marketing and member materials and to make oral interpreter services available free of charge.

ODM recognizes that some members may have other special communication needs, such as limited reading proficiency, limited health literacy, visual impairment, and hearing impairment. In such cases, MCPs are required to provide assistance to members, maintain a centralized database of special communication needs, and provide related services; MCPs must also share this information with providers. ODM monitors this requirement as part of the administrative compliance audit.

State and MCP efforts to reduce disparities in healthcare

ODM uses the U.S. Department of Health and Human Services Office of Minority Health definition of health disparities as “a particular type of health difference closely linked with social or economic disadvantage.” Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location).

ODM’s quality strategy prioritizes health equity as the ultimate aim for improvement efforts. To emphasize the importance of addressing healthcare disparities and augmenting cultural competency, ODM has dedicated a full-time position to lead health equity improvement efforts. This position coordinates ODM efforts to address disparities, including but not limited to: developing and implementing the ODM health equity strategy; analyzing data to strategically pinpoint improvement needs; staying abreast of current research regarding disparity reduction, social determinants, and health equity; fostering relationships with state, local and community-based health equity partners; and working with MCPs and other stakeholders on quality improvement efforts targeting disparities within each of ODM’s population streams.

Support of ODM’s health equity efforts includes having MCP health equity representatives actively involved in improvement initiatives, determining the root cause of inequities, developing targeted

interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts. These efforts move beyond agenda setting, and instead focus on the work needed for change to occur, and place greater responsibility for improvement on all parties participating in improvement efforts.

In their annual QAPI submissions, plans are not only required to describe efforts to reduce health disparities, but are also required to describe how the MCP will promote service delivery in a culturally effective manner to all members. Each of these components requires the plans to specify measures that will be used for tracking improvement. A copy of the QAPI requirements can be found in Appendix C. It is important to note that two of Ohio's contracted MCPs--United Healthcare Community Plan and Molina Healthcare--have obtained the NCQA's Multicultural Health Care distinction which is offered to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.

ODM coordinated efforts to address disparities occur within each of ODM's population streams. For each of these data is used to identify and target areas in priority regions where disparities in optimal outcomes are the highest. Current health equity efforts are focused on reducing infant mortality through increasing the use of progesterone, capitalizing on MCP partnerships with community-based organizations to address additional contributors to infant mortality, and reducing disparities in hypertension control between African American and Caucasian Medicaid members in control of hypertension. These efforts are discussed in more detail in Section V, Improvements and Interventions.

National Performance Measures

Although ODM does not currently require the MCPs to report on any CMS-developed measures, ODM establishes performance measure standards and monitors MCP performance on nationally recognized performance measure sets (e.g. HEDIS and AHRQ) to evaluate MCP performance on ODM Quality Strategy goals within each population stream. A limited number of measures are informational only and have no associated standards, incentives, or sanctions.

For a full list of ODM-required Performance Measures organized by population stream, please see Appendices A (Medicaid Managed Care measures) and B (MyCare of Ohio measures). These measures are appended to ODM's Provider Agreements with the MCPs.

Monitoring, Compliance & External Quality Review

There are a number of mechanisms for ensuring compliance and monitoring the performance of Ohio's MCPs, including: MMC and MCOP contractual requirements, data quality standards, performance measures, and reviews by Ohio's External Quality Review Organization.

Monitoring and Compliance with Contractual Requirements

ODM enters into a contract (provider agreement) with each MCP prior to its provision of medically necessary, Medicaid-covered services, as defined in Ohio Administrative Code (OAC) 5160-1-01, to the Medicaid population. ODM's Bureau of Managed Care Compliance and Oversight monitors health plan compliance with the provider agreement. If the MCP is found to have violated this contract, or any other applicable law, rule or regulation, sanctions are imposed in accordance with ODM's Compliance

Assessment System (CAS). The CAS, along with other mechanisms used for monitoring and improving performance, is discussed in more detail in Section V: Improvement Initiatives and Interventions.

ODM has established an extensive set of evaluation standards that assist ODM in maintaining MCP accountability for contract requirements and determining the overall value of the program. These standards can be divided into two distinct categories: standards for data quality and standards for evaluating MCP performance in key program areas.

MCP data with data quality standards and/or submission requirements include: encounter data; Healthcare Effectiveness Data and Information Set (HEDIS) data; care management data; appeals and grievances data; utilization management data; Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, third party liability data, and primary care provider data. Adherence to quality standards is crucial due to the use of these data sets to assess MCP performance assessments, and, in conjunction with cost reports, to determine premium payment rates. The data quality standards ensure a high level of quality in the data reported to ODM.

MCP performance measures evaluate MCP performance in core program areas, including: access, clinical quality, and consumer satisfaction. These measures generally follow the Healthcare Effectiveness Data and Information Set (HEDIS), a standard measurement tool for the Medicaid managed care industry. Measures with a minimum performance standard are used to determine MCP noncompliance sanctions. A limited number of measures are informational only and have no associated standards, incentives or sanctions. ODM established measures and standards to evaluate MCP performance are contained in Appendices A and B.

Comparison of MCP performance on these measures to minimum performance standards helps determine what percentage of new members are assigned to the plan (quality based assignment) and the percentage of payments that are withheld (quality withhold). More information about the use of performance measure based incentives to improve population health outcomes can be found in Section V, Improvements and Interventions.

External Quality Review and Non-duplication of EQR Activities

States contracting with MCPs for the provision of health care services are required to arrange for annual, external, independent reviews of the quality, timeliness, and accessibility of services provided by MCPs to enrolled individuals. ODM's contracted EQROs, Island Peer Review Organization and QSource, provide external quality review (EQR) services for the State's Medicaid managed care plans.

An external quality review may consist of mandatory and optional activities as specified by 42 CFR §438.358.

ODM's EQROs conduct reviews of MCP compliance with state and federal standards, validates aggregate performance measure results, conducts member and provider surveys, validates MMC performance improvement projects, produces the annual EQR technical report, and conducts other general and mandatory activities. Information and recommendations generated by the EQROs assist ODM in determining needed changes to the quality strategy and associated guidance, monitoring, and

implementation mechanisms. Any issues of non-compliance are addressed in accordance with ODM's compliance assessment system (e.g. corrective action plans, monetary penalties, etc.)

ODM strives for EQR activities to be value added and to supplement ODM's oversight mechanisms. In order for these activities also to be cost-effective and efficient, ODM is committed to the non-duplication of activities through the use of information from Medicare or private accreditation reviews as allowed in CFR §438.360. To that end, ODM has implemented the deeming option permitted by 42 CFR §438.362. For the administrative review that will be conducted in spring of 2020, QSource, on behalf of ODM, completed a crosswalk of NCQA standards with applicable CFRs to identify standards that are fully comparable and eligible for deeming. ODM accepted the recommendations issued in QSource's full report with regard to federal regulations that could be deemed (see Appendix D).

MCP Accreditation

MCPs must hold and maintain, or must be actively seeking and working towards, accreditation by the National Committee for Quality Assurance (NCQA) for the Ohio Medicaid line of business. The plans must achieve and maintain an "Excellent", "Commendable" or "Accredited" status. At present, ODM only accepts NCQA accreditation standards. Compliance with this requirement is assessed by ODM on an annual basis.

III: State Standards

The state has established access to care standards in the MMC and MCOP contracts in order to support the overall goals and objectives for the program.

Access Standards

Access standards relating to the assurance of service availability, adequate capacity and services, appointment availability, and coordination and continuity of care allow ODM to achieve its strategic goals of continuously improving population health and healthcare quality, promoting value over volume, and increasing health equity across all population streams. These standards are set forth in Ohio Administrative Code (OAC) and ODM's MMC and MCOP provider agreements.

Service Availability

Maintain and monitor a network of appropriate providers

ODM's MMC and MCOP Provider Agreements (Appendix H, Provider Panel Specifications) require MCPs to provide or arrange for the delivery of all medically necessary, Medicaid-covered health services. This includes assuring that they are in compliance with provider panel access standards by considering the following: anticipated Medicaid membership; expected service usage based on a consideration of member health care needs; the number and types (in terms of training, experience, and specialization) of panel providers required to deliver contracted Medicaid services; the number of providers accepting new Medicaid patients; the relative geographic location and distance, as well as travel time required between panel providers and Medicaid members; appointment availability; and whether provider locations provide appropriate physical access for Medicaid members with disabilities. Additionally, if the MCP's contracted provider panel is unable to provide Medicaid-covered services, the MCP is required to adequately cover services provided by an out-of-network provider.

MCPs are required to submit their panel of network providers to ODM in order to demonstrate that the range of preventative, primary care and specialty services offered is adequate in number, mix and geographical distribution to meet the needs of the anticipated number of members in the service area.

For managed care members with special health care needs or who are determined to need a course of treatment or regular care monitoring, ODM requires MCPs to have mechanisms in place in order to allow direct access to specialists appropriate for the member's condition and identified needs.

ODM monitors the adequacy of provider networks through examining survey, utilization, and complaints data. Corrective action is taken when necessary. Beginning in January 2019, ODM will quarterly assess MCP compliance with time and distance standards using internal mapping and analytics software.

Assure providers meet state standards for timely access to care and services

Standards for timely access to care and services are set forth in OAC rules and include the following: immediate treatment and triage of members with emergency care needs when they first come to their primary care provider; treatment of members with persistent symptoms before the end of the following working day after their initial contact with their primary care provider; meeting requests for routine care within six weeks of the request; processing service authorization requests within fourteen calendar days of receiving the request; authorizing emergency-prescribed outpatient drugs within seventy-two hours.

MCPs are required to provide assurance that their contracted provider hours are comparable with Medicaid FFS or commercial services and that timely access is assured through the provision of service availability 24 hours, seven days a week, when medically necessary. MCPs are required to establish mechanisms to ensure that panel providers comply with timely access requirements.

Direct access of females to a women's health specialist

MCPs are required to ensure that their provider network provides female enrollees with direct access (without referral) to a women's health specialist, including an obstetrician or gynecologist, necessary to provide women's routine preventive health care services.

In addition, MCP members are permitted to self-refer to Title X services provided by any qualified family planning provider (QFPP). The MCP is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the MCP.

Second opinions from qualified health care professionals

MCPs allow for a second opinion from a qualified health care professional within or outside of the panel, as appropriate, when requested by a member. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.

Adequate and timely coverage of out-of-network services and provider coordination with the MCP with respect to payment

Ohio's contracts require MCPs to ensure that services not available in-network are covered in a timely and adequate manner by an out-of-network provider until accommodated by the MCP provider network. MCPs must coordinate with the out-of-network providers with respect to payment and ensure

that the provider agrees with the applicable requirements. MCPs establish processes and procedures for the submission of claims for services delivered by out-of-network providers. MCPs are also required to share information with out-of-network providers in order to assist members in accessing medically necessary, Medicaid-covered services. This information sharing is intended to assist non-panel providers in recognizing MCP membership, accessing information needed to provide services and, if applicable, successfully submitting claims to the MCP.

Additionally, OAC requires that MCPs assure that services viewed as medically necessary for maintaining the stabilization of an emergency medical condition be provided and covered twenty-four hours a day, seven days a week. The MCPs must cover these services regardless of whether they are obtained within the MCP's provider panel as long as they pre-approved in writing to the requesting provider by a plan provider or other MCP representative.

Assurance of Adequate Capacity and Services

Assurance and documentation of capacity to serve expected enrollment

Because ODM uses the Managed Care Provider Network (MCPN) to assess whether MCPs meet all the panel requirements that are identified in the MMC and MCOP provider agreements, MCPs are required to enter all network providers into the MCPN. Additionally, MCOPs assure that providers submitted to the Managed Care Provider Network (MCPN), or listed in MCOP published directories, are available to serve both dually eligible and Medicaid only members of the MCOP.

On a weekly basis, the MCPs are sent an electronic file that contains the MCP's provider panel as reflected in the ODM MCPN database. This allows for a reconciliation of any discrepancies between what the plan's panel and what is contained within the database.

Mechanism/monitoring to ensure compliance by providers

ODM monitors provider compliance using a number of mechanisms, including: data submission for monitoring provider capacity and member service utilization; geographic software, used to determine the time and distance of provider locations; examining appeals by members or their authorized representatives; and reviewing grievances expressing dissatisfaction with any aspect of the MCP's or provider's operation, provision of care services, activities or behaviors.

The MCP's written policies and procedures for an appeal and grievance system for members must be made available for review by ODM and must include: the processes for filing grievances and appeals with the MCP and the process by which members may access the state's hearing system through the Ohio Department of Job and Family Services (ODJFS).

OAC requires that MCPs provide their contracting providers with their policies and procedures regarding the actions the MCP may take in response to occurrences of undelivered, inappropriate or substandard health care services. This includes the reporting of serious deficiencies to the appropriate authorities.

MCP provider network compliance with standards set forth by the MMC or MCOP provider agreement is assessed at least quarterly. When there is a deficiency, a nonrefundable sanction for each category (practitioners, PCP capacity, hospitals), for each county may be assessed. ODM may assess additional

sanctions if an MCP violates any other provider panel requirements or an MCP's member has experienced problems accessing necessary services due to the inadequacy of the MCP's provider panel.

Culturally competent services to all enrollees

MCPs are responsible for promoting the delivery of services in a culturally competent manner, to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds. The MCP must comply with the requirements specified in OAC rules and provider agreements for providing assistance to members with LEP and eligible individuals. This includes free translations of marketing and member materials into non-English languages prevalent in the MCP's service area.

All MCP subcontractors must also not discriminate in the delivery of services based on the member's race, color, religion, gender, genetic information, sexual orientation, age, disability, national origin, military status, ancestry, health status, or need for health services.

MCPs must inform providers of their obligation to provide oral translation, oral interpretation, and sign language services to the MCP's members. These policies must include: the provider's responsibility to identify those members who may require such assistance; the process the provider is to follow in arranging for such services to be provided; and the specification of whether the MCP or the provider will be financially responsible for the costs of providing these services. Both MCPs and providers are prohibited from holding members liable for the costs of these services.

The MCP must record special communication needs (i.e., those with LEP, limited reading proficiency [LRP], visual impairment, and hearing impairment) when identified by any source and the resulting provision of related services for all its members in a centralized database. 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 primary care provider (PCP) who speaks the primary language of an LEP member, when such a provider is available. The MCP must share specific communication needs information with its providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable.

MCPs are required to assign a staff person to coordinate, document, and assess the provision of sign language, oral interpretation, and oral translation services.

MCPs are required to use person-centered language in all communications with eligible individuals and members. Person-first language resources are available from national organizations, including the Centers for Disease Control and prevention, The Arc, and the National Inclusion Project.

Additionally, MCPs must conduct staff training sessions on subjects including disability competency, access, cultural sensitivity, person-centered care delivery approaches and independent living philosophies.

Coordination and Continuity of Care

ODM's transition of care policies have evolved since their genesis in 2006 and are consistent with 42 CFR 438.62 and the Ohio Administrative Code. The overall intent of these policies is to provide for smooth continuity of care and benefits for Medicaid recipients and to prevent disruptions and gaps in medical

services that might negatively impact members' health. These policies are explicated in the MMC and MCOP provider agreements (Appendix C, Plan Responsibilities). They address many transition points including: enrollment of newly eligible members; transition from Medicaid fee-for-service (FFS) to managed care; terminations from MCP; and members changing MCPs.

If an eligible individual, as defined in OAC rule 5160-26-01 or 5160-58-01, contacts the MCP, the MCP is required to 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, the MCP is required to provide an assurance that all MCPs cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.

If a pending member (an eligible individual subsequent to MCP selection or assignment to an MCP, but prior to his or her membership effective date) contacts the selected MCP, the MCP shall provide any membership information requested, including but not limited to explaining how to access services as an MCOP member and assistance in determining whether current services require prior authorization. The MCOP shall also ensure 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.

If a pending member (i.e., an eligible individual subsequent to MCP selection or assignment to an MCP, but prior to their membership effective date) contacts the selected MCP, the MCP shall 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 shall also ensure 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.

For Medicaid pending members who do not select a primary care provider (PCP), the MCP's second rank for assignment is based on an algorithm that integrates historical FFS and MCP PCP claims utilization.

Transition of Care for Members moving from Medicaid FFS to Managed Care

When new populations transition to managed care, ODM requires the enrolling MCP to develop and implement processes that include pre-enrollment planning, care management, service continuation, out-of-panel provider reimbursement and service documentation. MCPs must provide care coordination for prescheduled health services, access to preventive and specialized care, care management, member services, and education with minimal disruption to members' established relationship with providers and existing care plans.

Beginning January 1, 2018, individuals are enrolled in managed care on the first day of the month in which Medicaid eligibility is determined. There will be no fee-for-service time period for most services.

MCPs will allow members to continue to receive services from network and out of network providers for a predetermined amount of time (e.g. 90 days) before an MCP can impose prior authorization, make a change to the service level, or transition a member to a panel provider.

MCPs are required to pay for claims for covered services provided to members during retroactive enrollment periods.

For services provided during retroactive enrollment periods that require FFS prior authorization as documented in Appendix DD of OAC 5160-1-60, OAC 5160-9-03 (regarding pharmacy claims), and all other FFS regulations that set forth prior authorization policy, the MCP may conduct a medical necessity review for payment. However, if the service was already reviewed and approved by FFS, the MCP must approve the service.

MyCare Ohio plans may also review to determine that home and community-based services were in accordance with the preexisting or current waiver services plan of care.

Upon a member's initial enrollment in MyCare Ohio, the MCOP provides transition of Medicare and Medicaid services in accordance with the requirements specified in Section 2.5.4 of the Three-Way for both contracted and non-contracted providers. Prior to the end of any required transition period, the MCOP shall inform the member and non-contracted provider of the effective date of any transition to a contracted provider, during a meeting of the trans-disciplinary care team or by another method documented in the care plan.

Upon receipt, the MCOP shall be able to process and use the FFS historic utilization, prior authorization and care management data files to assess pending members' risk stratification levels, to coordinate care and to adhere to transition requirements. When waiver service coordination data is omitted from the file transfer for a pending member enrolled in the FFS PASSPORT, or Assisted Living waiver, the MCOP must reconcile the enrollment or data error with the PASSPORT Administrative Agency (PAA). When waiver service coordination data is omitted for pending members in the Ohio Home Care waiver, the MCOP notifies its contract administrator to request enrollment reconciliation and/or data completion.

f. The MCOP is responsible for implementing transition of care processes that prevent access problems for members who are transitioning from the FFS pharmacy benefit administrator to an MCOP. The transition of care processes for prescribed drugs shall be consistent the requirements outlined in Medicare Part D.

MCOPs must make express arrangements to obtain current treatment plans from Ohio Department of Mental Health and Addiction Services (OhioMHAS) certified providers when a member's behavioral health services qualify for transition pursuant to Section 2.5.4 of the Three-Way.

Transition of Care for Members Changing MCPs

Upon notification from a member and/or provider of a need to continue services, the MCP must allow a member transitioning from another MCP to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services. Upon request from the enrolling MCP, the disenrolling MCP is to provide historical utilization and prior authorization data for the disenrolled member as expeditiously as the situation warrants. The MCP may prior authorize these services or assist the member to access services through an in-network provider when any of the following occur:

- The member's condition stabilizes and the MCP can ensure no interruption to services;
- The member chooses to change to a network provider;
- The member's needs change to warrant a change in service; or
- Quality concerns are identified with the provider.

Effective July 1, 2018, the enrolling MCP must honor the disenrolling MCP's prior authorization for all new members until the enrolling MCP is able to conduct a medical necessity review. Furthermore, ODM is working with the MCPs to develop a standardized data exchange process to facilitate transition of care activities between plans in compliance with 42 CFR 438.62.

MCP coordination for enrollees with special healthcare needs and dually-eligible individuals receiving long-term services and supports

ODM requires the MCPs to identify, assess, coordinate and monitor care for members with complex needs including those with special healthcare needs and those in need of long-term services and supports (LTSS). Each MCP must have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs or receiving LTSS. The MCP must specify the mechanisms used in the annual submission of the QAPI program to ODM.

Additionally, the MCOP contract requires coordination with any Medicare Advantage Plan that is the primary payer of Medicare services, if applicable, in an effort to reduce gaps or duplication of services.

If a member transfers between MCOPs, ODM requires that the disenrolling MCOP obtain the member's written consent and promptly transfer the current assessment and care plan, inclusive of the waiver service plan, to the enrolling MCOP prior to the new enrollment effective date.

Protect enrollee privacy when coordinating care

The MMC and MCOP provider agreements require the implementation of 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.

Mechanisms to identify and assess persons with special health care needs

Both the MMC and MCOP provider agreements require the Care Management Director to ensure that plan-specific mechanisms are implemented for identifying, assessing, and developing a care plans for individuals with special health care needs.

Furthermore, each MCP is required to have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. These mechanisms are specified in the annual submission of the plan's QAPI program to ODM.

Treatment plans incorporate participation from the Medicaid enrollee and include consultation with providers and specialists

Each MCP is required to ensure members are able to access care management and medically necessary services when needed. There must be a clear delineation of roles and responsibilities between the MCP and other entities that are responsible for, or are contributing to, care management in order to assure no duplication or gaps in services.

MCPs must conduct or arrange for an assessment that is appropriate to the member's unique needs and circumstances. As required by 42 CFR 438.208, ODM requires that contracted MCPs administer the ODM-approved standardized pediatric and adult needs assessment tool to all new members within 90 days of enrollment. The health risk assessment assists the MCP in evaluating the member's risk

stratification and identify potential needs for care management. The goal of the assessment is to identify immediate clinical (physical, behavioral and long term service and support need, as appropriate), social and safety needs in order to facilitate timely follow-up action. The MCP will identify the triggers for completion of comprehensive assessments or disease-specific assessments. Input from the PCP, member, and caregivers is critical. MCPs must have criteria in place for determining when to conduct a reassessment which includes a change in member needs, a significant change event, a change in diagnosis, or a request from the member or his or her provider.

Using a person-centered process and the results of the most recent assessment, the MCP will develop an individualized care plan that includes prioritized, measurable goals, interventions, and desired outcomes. Goals must be developed with and should be agreed to by the member and documented in the care plan. Care plan goals should be congruous with the priority issues identified by the PCP, PCMH, etc., so that the MCP can support the provider-patient relationship. The MCP will implement, monitor, and revise the care plan to address gaps in care.

The MCP will assign care managers and use a multidisciplinary team when a member's physical, psychosocial, and/or behavioral conditions would benefit from a range of disciplines with different, but complementary skills, knowledge and experience working together to deliver an integrated, comprehensive approach to care management.

Contact schedules, staffing ratios and data submission requirements are also in place to ensure members receive the highest level of care management appropriate for their risk level.

Service Coverage and Authorization

Amount, Duration, and Scope

Ohio Administrative Code (OAC) requires that MCPs ensure that members have access to all medically necessary services covered by FFS Medicaid. All required services must be sufficient in amount, duration, and scope to be reasonably expected to achieve the purpose for which they are furnished. Additionally, the amount, duration, or scope of a required service cannot be arbitrarily denied or reduced solely because of the member's diagnosis, type of illness, or condition.

The MCP may elect to provide services that are in addition to those covered under the Ohio Medicaid FFS program. Before the MCP notifies potential or current members of the availability of these services, they must first notify ODM and advise ODM of plans to make such services available. If an MCP elects to provide additional services, the MCP must ensure to the satisfaction of ODM that the services are readily available and accessible to members who are eligible to receive them. Additional benefits must be made available to members for at least six (6) calendar months from date approved by ODM.

The MCP must give its members and ODM ninety days prior notice when decreasing or ceasing any additional benefits. When an MCP finds that it is impossible to provide 90 days prior notice for reasons beyond its control, as demonstrated to ODM's satisfaction, ODM must be notified within at least one business day.

The MCP must have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. MCPs must ensure that decisions rendered through the UM program are based on medical necessity.

Additionally, the UM program must be based on written policies and procedures that specify the following: the information sources used to make determinations regarding medical necessity; the criteria, based on sound clinical evidence, for making UM decisions and the specific procedures for appropriately applying the criteria; the availability of written utilization management criteria to both contracting and non-contracting providers; and describe how the MCP will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

ODM requires that the MCP's UM program ensure and document that the UM program is annually reviewed and updated; that a senior physician is assigned to and involved in the UM program; that appropriate, qualified, licensed health professionals assess the clinical information used to support UM decisions; that board-certified consultants assist in making medical necessity determinations when necessary; that UM decisions are consistent with clinical practice guidelines; that the reason for each denial of a service is based on sound clinical evidence; and that compensation by the MCP to individuals or entities that conduct UM activities does not incentivize denial, limitation, or discontinuation of medically necessary services to any member. MCPs report on these monitoring practices in their QAPI submissions to ODM.

MCPs are prohibited from retroactively denying a prior authorization request as a utilization management strategy and must permit retrospective review of a claim that was submitted for a service where PA was required, but not obtained.

Additionally, ODM may request details of drug utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. and require changes to such programs if they cause barriers to care.

Medical Necessity

The MCP is responsible for determining medical necessity for services and supplies requested for their members. Medical necessity is met if the service:

- Meets generally accepted standards of medical practice;
- Is clinically appropriate in its type, frequency, extent, duration, and delivery setting;
- Is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
- Is the lowest cost alternative that effectively addresses and treats the medical problem;
- Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
- Is not provided primarily for the economic benefit or convenience of anyone other than the recipient.

If a member is unable to obtain medically necessary services offered by Medicaid from an MCP panel provider, the MCP must cover the services out-of-network in an adequate and timely manner, until the MCP is able to provide the service from its network of providers.

MCPs may place limits on the provision of a service based on medical necessity or for of utilization control purposes, as long as the services furnished can be reasonably expected to achieve their purpose. However, ODM retains the right to make the final determination on medical necessity in specific member situations.

Service Authorization

MCPs are required to provide their contracting and non-contracting providers with a list of benefits that require prior authorization approval and the written policies and procedures for initial and continuing service authorization. These policies and procedures must include the process and format for submitting prior authorization requests; the time frames in which the MCP will respond to these requests; how the provider will be notified of the MCP's decision regarding the authorization request; and the procedures to be followed in appealing the MCP's denial of a prior authorization request.

All MCPs are required to designate staff specifically responsible for resolving individual provider issues, including problems with claims payment, prior authorizations and referrals. Written information must be provided to their contracting providers detailing how to contact these designated staff.

The MCPs written policies and procedures for processing authorization requests from their providers and members must be made available for ODM's review when requested. The MCPs must ensure through documentation that when requests for initial and continuing service authorization are processed the following occurs: review criteria for authorization decision are consistently applied; the requesting provider is consulted when necessary; and that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than that requested, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

ODM also requires that MCPs provide authorization decisions within prescribed timelines. For standard authorization decisions, the MCP must provide notice to the provider and member as expeditiously as the member's health condition requires but no later than ten calendar days following receipt of the request for service. If a provider or the MCP determines that the standard authorization timeframe could seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function, the MCP must make an expedited authorization decision and provide notice of the decision within forty-eight hours after receiving the service request.

If requested by the member, provider, or MCP, standard authorization decisions may be extended up to fourteen additional calendar days. However, if the MCP requests an extension, documentation illustrating how the extension is in the member's best interest must be submitted and prior approval for the extension must be approved by ODM. If ODM approves the MCP's extension request, the MCP must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with the decision. The MCP must carry out

its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Prior authorization decisions for covered outpatient drugs must be made by telephone, or other telecommunication device within twenty-four hours of the initial request. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the MCP is unable to obtain the information needed to make the prior authorization decision within twenty-four hours, the decision timeframe has expired, and the MCP must give notice to the member.

An MCP must give members and their requesting provider written notice of action when a requested service is denied, limited, reduced, suspended, or terminated. This written notice must be given within specified timeframes outlined below.

- When a decision is made to deny or limit authorization of a requested service, including the type or level of service, the MCP must issue a notice of action simultaneously with the MCP's decision.
- If previously authorized services are reduced, suspended or terminated prior to the member receiving the services, the MCP must give notice fifteen calendar days before the date of adverse benefit determination, except if probable recipient fraud has been verified, in which case the MCP must give notice five calendar days before the date of adverse benefit determination.
- MCPs must give notice simultaneously with the MCP's action to deny either the entire claim or part of a claim when a service is not covered by Medicaid or is determined to not be medically necessary. If a prior authorization, appeal or grievance resolution does not occur in a timely manner, the MCP must give notice simultaneously with becoming aware of the untimely resolution. A service authorization decision not reached within the timeframes specified in OAC rule 5160-26-03.1 constitutes a denial and is thus considered to be an adverse action.

Both the MMC and MCOP provider agreements require that monitoring efforts include the following activities: an annual review of their prior authorization procedures to determine that they do not unreasonably limit a member's access to Medicaid-covered services; an annual review of the procedures providers are to follow in appealing the denial of a prior authorization request to determine that the process does not unreasonably limit a member's access to Medicaid-covered services; and ongoing monitoring of service denials and utilization in order to identify services which may be underutilized.

MCPs are required to maintain a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. Records must include member identifying information (e.g., MMIS ID), request type (standard or expedited), the service requested, the date the initial request was received, any extension requests, the decision made, the decision date, the date the member notice was sent, and, if denied, a narrative explaining the basis for denial which includes the denial rule citation field. This information must be submitted to ODM upon request.

MCPs have a secure internet-based website for contracting providers through which providers can confirm an individual's enrollment and through which providers can submit and receive responses to prior authorization requests.

Structure and Operations Standards

MCPs are required to have written policies and procedures for the selection and retention of providers that prohibit discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

Credentialing and Re-credentialing

ODM requires that MCPs use the standardized credentialing form and process as prescribed by the Ohio Department of Insurance when initially credentialing and when re-credentialing providers in connection with policies, contracts, and agreements providing basic health care services. MCPs must ensure that the provider has met all applicable credentialing criteria before the provider can be listed as a panel provider with the MCP. If any MCP delegates the credentialing or re-credentialing of subcontractors to another entity, the MCP must retain the authority to approve, suspend, or terminate any subcontractors.

Upon ODM's request, the MCP must be able to demonstrate the record keeping associated with maintaining this documentation and/or submit documentation verifying that all necessary contract documents have been appropriately completed.

ODM provider agreements with both MMCs and MCOPs prohibit the employment or contracting of providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act. MCPs must notify ODM when credentialing is denied for program integrity reasons.

Enrollee Information & Provider Selection

Basic rules & Information for potential enrollees

To assist potential members, ODM maintains current information about the Managed Care Program on its website (www.medicaid.ohio.gov). This includes information about Medicaid and MyCare Ohio eligibility (including groups that are excluded and those who are not mandated to enroll), the Medicaid Managed Care Benefit Package, links to each of the MCP websites, and a comparison of Ohio Medicaid Managed Care Plans on key performance indicators.

Additionally, the ODM-contracted Medicaid Consumer Hotline (<http://www.ohiomh.com/>) operates a statewide toll-free telephone center and website that assists eligible individuals in selecting an MCP for Managed Medicaid or for MyCare Ohio. The hotline is responsible for providing unbiased education and selection services for the Medicaid managed care program. This includes information on the plans that serve a particular county and includes a search option for determining whether a provider is part of a particular plan's provider panel. The hotline also helps those applying for Medicaid by explaining Medicaid-covered services, finding a Medicaid health care provider, and completing Medicaid applications.

Eligibility Redetermination

Medicaid eligibility is re-determined every 12 months, unless the agency receives information about a change that may affect eligibility in the interim. Individuals who cannot be passively renewed have thirty days from the Medicaid renewal form date to provide the requested information, sign and return the form. Individuals can provide information online at Benefits.ohio.gov, by telephone, or by mailing or delivering the renewal form in-person to a County Department of Job and Family Services (CDJFS) location. If the form is not received within thirty days, enrollment is terminated.

Medicaid recipients who have benefits terminated have 90 days to request a hearing to appeal the decision and a new application is not required. If a hearing officer agrees to reinstate the benefits, coverage is retroactive to the date of termination. If a hearing is requested within 15 days, the recipient maintains benefits until the hearing.

Reinstated Medicaid eligibility begins on the first day of the month following the month Medicaid was terminated. If coverage is terminated, hospitals and community health centers can help eligible individuals reenroll through presumptive eligibility (PE). Individuals may be eligible for PE if they are not currently receiving Medicaid benefits and have not had a PE span of coverage in the past twelve months, are a resident of Ohio, and are a U.S. citizen or has a satisfactory immigration status.

In the event that an MCP member loses Medicaid eligibility and is automatically terminated from the MCP, but regains Medicaid eligibility within a period of sixty days or less, his or her membership in the same MCP must automatically be re-instated. ODM confirms the eligible individual's MCP membership to the MCP via an ODM-produced roster of new members, continuing members, and terminating members.

MCPs are required to provide membership notices, informational materials, and instructional materials to members and eligible individuals in a manner, language and format that can be easily understood. The determination of whether materials comply with this requirement is at the sole discretion of ODM. At least annually, ODM or its designee provides current MCP members with an open enrollment notice that describes the managed care program and includes information on the MCP options in the service area, as well as other information regarding the managed care program as specified in 42 CFR 438.10. Open enrollment takes place each year in November.

Additionally, member materials must be printed in the prevalent non-English languages of members in the MCP's service area, be available in written format and alternative formats in an appropriate manner that takes into consideration special needs of the member including visually limited and limited reading proficiency members, and be provided in a manner and format that may be easily understood.

To assist MCPs, ODM conducts an annual analysis of Medicaid eligible individuals to identify whether there are any prevalent non-English languages in the MCP's service areas. ODM notifies the MCPs of any languages that are identified as prevalent for the purpose of translating marketing and member materials. The MCPs are responsible for making oral interpreter services for all languages available free of charge to all members and potentially eligible individuals.

The MCP must comply with the requirements specified in OAC rule for providing assistance to members and eligible individuals with limited English proficiency (LEP). In addition, the MCP must provide written translations of certain MCP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

- 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 ODM, the Hotline, 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 primary care provider (PCP) who speaks the primary language of an LEP member, when such a provider is available.
- The MCP must share specific communication needs information with its providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable.
- The MCP must submit to ODM, upon request, 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).

Each MCP must establish and operate a member services toll-free telephone number. This telephone line must have services available to assist hearing-impaired members and LEP members in the primary language of the member.

In addition, the MCP provider directories are required to indicate the availability of foreign-language speaking PCPs and specialists, the specific foreign language(s) spoken, and 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.

All MCPs are required to have a member services program that assists MCP members and eligible individuals seeking information about MCP membership, with the following:

- Accessing Medicaid-covered services;
- Obtaining or understanding information on the MCP's policies and procedures;
- Understanding the requirements and benefits of the plan;
- Resolving concerns, questions, and problems;
- Filing of grievances and appeals;
- Obtaining information on state hearing rights;

- Appealing to or filing any complaints of discrimination on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status, or need for health services in the receipt of health services; and
- Accessing sign language, oral interpretation, and oral translation services.

The MCP must ensure that these services are provided at no cost to the eligible individual or member. The MCP must designate a staff person to coordinate and document the provision of these services. The MMC and MCOP provider agreements also require that the MCPs acknowledge that they are prohibited from holding a member liable for the cost of services provided to the member in the event that the ODM fails to make payment to the MCP.

The MMC and MCOP provider agreements require all MCPs to have an internet-based provider directory available in the same format as its ODM-approved provider directory or link to the Medicaid Consumer Hotline's online provider directory so that members can electronically search for the MCP panel providers based on name, provider type, and geographic proximity. MCP provider directories must include all MCP-contracted providers (except as specified by ODM), as well as certain ODM non-contracted providers. If an MCP has one internet-based directory for multiple populations, each provider must include a description of the populations they serve.

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 receiving a response by return e-mail or phone call. The MCP's responses to questions or comments must be made within one business day of receipt. Grievances submitted in writing must be acknowledged by the MCP in writing within three business days of receipt. Grievance resolutions, including member notification, are required to meet the following timeframes:

- A grievance regarding access to services must be resolved within two business days of receipt.
- A non-claims-related grievance must be resolved within thirty calendar days of receipt.
- A claims-related grievance must be resolved within sixty calendar days of receipt.

If the MCP's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service or billing of a member due to the MCP's denial of payment for that service, the MCP must notify the member of his or her right to request a state hearing, if the member has not previously been notified.

Although the MCP member website cannot be the only way that MCP members are notified of new and/or revised MCP information, they are required to be regularly updated to include the most current ODM-approved materials.

The MCP member website must also include the following information to members and the general public without requiring them to establish log in information:

- MCP contact information (e.g., MCP's toll-free member services phone number, service hours, and closure dates);
- A listing of the counties the MCP serves or an indication that the MCP serves the entire state;

- The ODM-approved MCP member handbook, recent newsletters and announcements;
- The MCP's on-line provider directory;
- Current version of the Member Handbook;
- A list of services requiring prior authorization (PA);
- The MCP's preferred drug list (PDL), including an explanation of the list and identification of preferred drugs that require PA, the MCP's list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCP's policy for coverage of generic versus brand name drugs;
- The toll-free telephone number for the 24/7 medical advice call-in system required by OAC;
- Contact information for scheduling non-emergency transportation assistance, including an explanation of the available services and how to contact member services for transportation services complaints; and
- Required information describing the Early Periodic Screening, Diagnostic and Treatment (EPSDT) Program (called Healthchek in Ohio).

ODM may require the MCP to include additional information on the member website as needed.

The MCP must publish a thirty (30) calendar day advance notice of changes to the MCP list of drugs requiring prior authorization via their website. The MCP must provide members with a printed version of its Preferred Drug List (PDL) and Prior Authorization (PA) lists upon request. The toll-free member services, 24/7 medical advice and transportation scheduling telephone numbers must be easily identified on with the MCP's website home page or a page that is a direct link from a contact button on the home page. The MCP must provide members with a printed version of its Preferred Drug List (PDL) and Prior Authorization (PA) lists upon request.

MCP provider directories must include all MCP-contracted providers as well as certain non-contracted providers as specified by ODM. ODM periodically reviews the' provider directories against information submitted by the plans. 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 also must: specify provider address(es) and phone number(s); consider the needs of individuals with limited proficiency in English or reading; include any PCP or specialist practice limitations; and indicate whether the provider is accepting new members.

ODM requires that providers be added to the internet directory within one week of submitting the provider to ODM's provider database. 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.

Prior to executing a provider agreement with ODM, all MCPs must develop a printed provider directory that must be prior-approved by ODM. Once approved, the directory may be regularly updated with provider additions or deletions by the MCP without ODM prior-approval.

Any revisions to the printed provider directory format must be approved by ODM prior to distribution.

In accordance with 42 CFR 438.10, MCPs must update their printed provider directory at least monthly, and internet provider directories must be updated no later than 30 calendar days after the MCP receives updated provider information.

Confidentiality

MCPs are bound by the same standards of confidentiality as employees of the State of Ohio, including, without limitation, the confidentiality requirements found in 42 CFR Part 431 Subpart F and ORC Section 5160.45, as well as 42 CFR Part 2 and ORC Section 5119.27, as applicable. MCPs are required to 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.

- Regarding confidentiality, OAC requires that MCPs develop and implement written policies that ensure that members have and are informed of the following rights:
- To receive all services that the MCP is required to provide pursuant to the terms of their provider agreement with ODM;
- To be treated with respect and with due consideration for their dignity and privacy;
- To be assured of confidential handling of information concerning their diagnoses, treatments, prognoses, and medical and social history;
- To request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected;
- To be afforded the opportunity to approve or refuse the release of information except when release is required by law; and
- To be assured that the MCP must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.

Enrollment and Disenrollment

Enrollment into Managed Care

Members eligible for Covered Family and Children (CFC) Medicaid, modified adjusted gross income (MAGI)-based Medicaid and Age, Blind or Disabled (ABD) Medicaid categories must be enrolled in a Medicaid managed care plan.

ODM requires that MCPs accept all eligible individuals who request MCP membership without regard to race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services. OAC prohibits the plan from the use of any discriminatory policy or practice.

ODM confirms all eligible individuals' MCP memberships via a monthly ODM-produced file of new members sent to the MCP. The MCP is not required to provide coverage until MCP membership is

confirmed via an ODM-produced roster except upon mutual agreement between ODM and the MCP or if the eligible individual is a newborn whose mother is enrolled in the MCP.

For MyCare Ohio plans, the eligibility of each individual is confirmed and eligible individuals residing in the service area required to enroll. Individuals are passively enrolled into a MyCare plan. A notice of mandatory enrollment (NME) is issued by ODM 60 days prior to the enrollment effective date.

If an individual does not make a choice following issuance of an NME, a reminder notice is sent 30 days prior to the enrollment effective date informing the individual of the passively enrolled plan and the effective date of enrollment.

As outlined in OAC 5160-58-02, individuals residing in mandatory service areas as permitted by 42 CFR 438.52 must be enrolled in MyCare Ohio if the individual meets all of the following criteria:

- Is age eighteen or older at the time of enrollment in the plan;
- Is eligible for Medicare parts A,B, and D, and full benefits under the Medicaid program; and
- Resides in a MyCare demonstration county in Ohio.

Native American Indians who are members of federally recognized tribes may choose to voluntarily enroll in a MyCare Ohio plan.

The following groups are excluded from enrollment in MyCare Ohio plans:

- Individuals enrolled in the Program of All-inclusive Care for the Elderly (PACE),
- Individuals who have credible third party health care coverage other than Medicare (as authorized by 42 USC 1395),
- Individuals who are inmates of public institutions as defined in 42 CFR 435.1010,
- Individuals with intellectual disabilities who have a level of care that meets the criteria specified in OAC rule 4123: 2-9-01 and receive services through a home and community waiver administered by the Ohio Department of Developmental Disabilities (DODD) and
- Individuals with intellectual disabilities who receive services through an intermediate care facility for individuals with intellectual disabilities (ICF-IDD)

Coverage of plan members is effective on the first day of the calendar month specified on the ODM-produced 834 electronic data interchange (EDI) file sent to the plan.

Exclusions from Mandatory Enrollment in Medicaid Managed Care

Exclusion from mandatory Medicaid Managed Care enrollment does not limit a Medicaid eligible individual's eligibility for basic FFS Medicaid or eligibility for other Medicaid benefits to which he or she is entitled. Individuals are excluded from MCP membership when excluded under a federally approved state plan or state law from MCP enrollment. Members of federally recognized tribes are also excluded from mandatory enrollment. Native Americans who are members of federally-recognized tribes are excluded from mandatory managed care enrollment but may choose to voluntarily enroll. Individuals enrolled on a Developmental Disabilities (DD) waiver have the option to enroll in Medicaid managed care.

Exclusions from Mandatory Enrollment in MyCare Managed Care

Native American Indians who are members of federally recognized tribes may choose to voluntarily enroll in a MyCare Ohio plan.

The following groups are excluded from enrollment in MyCare Ohio plans:

- Individuals enrolled in the Program of All-inclusive Care for the Elderly (PACE),
- Individuals who have credible third party health care coverage other than Medicare (as authorized by 42 USC 1395),
- Individuals who are inmates of public institutions as defined in 42 CFR 435.1010,
- Individuals with intellectual disabilities who have a level of care that meets the criteria specified in OAC rule 4123: 2-9-01 and receive services through a home and community waiver administered by the Ohio Department of Developmental Disabilities (DODD) and
- Individuals with intellectual disabilities who receive services through an intermediate care facility for individuals with intellectual disabilities (ICF-ID).

Disenrollment from Medicaid Managed Care

Reasons for disenrollment. Requirements and limitations regarding disenrollment from membership in an MCP are codified in OAC rule and apply to all MCPs. ODM will disenroll a member from a Medicaid managed care (MMC) plan for any of the following reasons:

ODM will disenroll a member from a Medicaid managed care (MMC) plan for any of the following reasons:

- Member moved outside of the MCP service area;
- Member becomes ineligible for Medicaid;
- Death;
- Non-Adult Extension member is authorized for nursing facility services (specific criteria outlined in OAC 5160-26-02.1 must be met prior to disenrollment);
- Member resides in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);
- Member has third party coverage;
- Member is not eligible for enrollment per OAC rule 5160-26-02;
- The MCP has requested disenrollment and ODM approved the request; or
- The provider agreement between ODM and the MCP is terminated.

ODM will disenroll a member from the MyCare Ohio program for any of the following reasons:

- Member becomes ineligible for full Medicaid or Medicare Parts A, B, or D;
- Member moved outside of the MCOP service area
- Death;
- Member resides in an ICF-IID or is enrolled on a Department of Developmental Disabilities (DODD) waiver;
- Member has third party coverage;

- The provider agreement between ODM and the MCOP is terminated; or
- Member is not eligible for enrollment in MyCare Ohio per OAC rule 5160-58-02.

Timing of disenrollment

Timeframes for termination vary based upon the reason for termination and are outlined in OAC rules 5160-26-02.1 and 5160-58-02.1.

Eligibility. If the member becomes ineligible for full Medicaid or Medicare parts A or B or D, termination of plan membership takes effect at the end of the last day of the month in which the member became ineligible. If a member is terminated from his or her MCP upon losing Medicaid eligibility but regains eligibility within a period of ninety days or less, his or her membership in the same plan is automatically be re-instated.

Death. If the member dies, plan membership ends on the date of death.

Incarceration. If ODM receives notification from the MCP, a CDJFS, or other public agency that the member is incarcerated for either more than fifteen business days or is incarcerated and has accessed non-emergent medical care, termination of plan membership takes effect the last day of the current month.

Residence in an ICF-IID or Enrollment on DODD Waiver. If a MyCare member is found by ODM to meet the criteria for an ICF-IID level of care and the MCP notifies ODM that the member has been placed in an ICF-IID or is enrolled on a DODD waiver, termination of plan membership takes effect on the last day of the month preceding placement in the ICF-IID facility or enrollment on the DODD waiver.

Nursing Facility (NF) Admission (excluding MyCare Ohio members and Adult Extension individuals). If an individual is authorized for NF services, ODM will terminate enrollment in managed care if the MCP has authorized NF services for no less than the month of NF admission and two complete consecutive months thereafter, the member has remained in the NF without any admission to an inpatient hospital or long-term acute care facility during that timeframe, the member is not using hospice services, and the discharge plan documents that NF discharge is not expected in the foreseeable future. MCPs are responsible for coverage of services through the disenrollment date.

Third party coverage. If the member has third party coverage and ODM determines that continuing MCP enrollment may not be in the best interest of the member, the effective date of termination of MCP membership will be determined by ODM, but the termination date will not be later than the last day of the month in which ODM approves the termination.

Third party coverage excludes individuals from enrollment in MyCare. If the individual is already enrolled in MyCare, the presence of third party coverage causes an auto disenrollment and prevents re-enrollment.

Termination of MCP contract. If the provider agreement between ODM and the plan is terminated or not renewed, the effective date of termination will be the end of the last day of the month of the provider agreement termination or nonrenewal.

Transitions between MCPs

Member initiated. A dual-benefits member may request disenrollment from the MCP and transfer between plans on a month-to-month basis any time during the year. Individuals enrolled in DODD waivers can voluntarily enroll or disenroll from managed care at any time. Children in custody may request a change in enrollment at any time. The switch to a new plan will be effective the beginning of the next effective month.

For all other membership groups, requests for different plans are limited. Individuals within these other groups may request a different plan during the time period between the date of initial enrollment and the first three months of plan membership, whether the first three months of enrollment are dual-benefits or Medicaid-only membership periods.

Plan changes can also be made during annual open enrollment which is currently scheduled in November. At least sixty days prior to the designated open enrollment month, ODM notifies eligible individuals by mail of the opportunity to change or terminate MCP membership and explains where to obtain further information.

The member, or authorized representative, may also request a different plan for any of the following reasons:

- When the member needs related services to be performed at the same time in a coordinated manner, but not all the services are available within the plan network, and the member's PCP or another provider determines that receiving services separately would subject the member to unnecessary risk;
- When the member has experienced poor quality of care and the services are not available from another plan contracted provider;
- If the member cannot access medically necessary Medicaid-covered services or cannot access the type of providers experienced in dealing with the member's health care needs;
- The PCP selected by a member leaves the MCP's panel and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the language is available and accessible in another MCP in the member's service area;
- The member moves out of the MCP's service area and a non-emergency service must be provided out of the service area prior to the member's termination date;
- ODM determines that continued membership in the plan would be harmful to the interests of the member.
- The MyCare Ohio member receiving long-term services and supports would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to and out-of-network provider with the plan and, as a result, would experience a disruption in their residence or employment; or
- The MCP does not, for moral or religious objections, cover the service the member seeks.

The member, or an authorized representative, must contact the MCP to identify providers of services before seeking a determination of just cause from ODM. When a member seeks a change or termination

in MCP membership for just cause, the member may make the request for just cause directly to ODM or an ODM-approved entity, either orally or in writing.

Requests for just cause may be processed at the individual level or case level as ODM determines necessary and appropriate. ODM reviews all requests for just cause within seven business days of receipt. ODM may request documentation as necessary from both the member and the MCP. ODM makes a decision within forty-five days from the date ODM receives the just cause request. However, if ODM fails to make the determination within this timeframe, the just cause request is considered approved. Regardless of the procedures followed, the effective date of an approved just cause request must be no later than the first day of the second month following the month in which the member requests change or termination.

If the just cause request is not approved, ODM must notify the member or the authorized representative of the member's right to a state hearing.

If a member submits a request to change or terminate membership for just cause, and the member loses Medicaid eligibility prior to action by ODM on the request, ODM must assure that the member's MCP membership is not automatically renewed if eligibility for Medicaid is reauthorized.

When a member requests a different plan, the request must be made by the member, or by the member's authorized representative, as defined in OAC 5160-26-01. Disenrollment takes effect on the last day of the calendar month or the succeeding calendar month, subject to state cut-off.

If a member requests disenrollment because he or she is a member of a federally-recognized tribe, as described in 42 CFR 438.14(a), they will be disenrolled after notifying the consumer hotline.

All member-initiated changes or terminations must be voluntary. Plans are not permitted to encourage members to change or terminate enrollment due to a member's race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services. Plans may not use a policy or practice that has the effect of discrimination on the basis of the above criteria

MCP initiated. An MCP may submit a request to ODM for the termination of a member if there was confirmed fraudulent behavior by the member, or uncooperative or disruptive behavior by the member or someone acting on the member's behalf to such an extent that the MCP's ability to provide services to either the member or other MCP members is seriously impaired.

The plan may not request termination due to a member's race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services.

If ODM approves the MCP's request for termination, ODM must provide written notice to the member, the authorized representative, the Medicaid Consumer Hotline, and the plan.

The MCP must provide Medicaid-covered services to a terminated member(s) through the last day of the month in which the MCP membership is terminated, notwithstanding the date of ODM approval of the termination request.

ODM may disenroll some or all Medicaid recipients if it is determined that the recipients' access to medically necessary services is jeopardized by ODM not renewing a contract or terminating a contract with an MCP.

For both Medicaid Managed Care and MyCare Ohio, ODM's EQRO may conduct focus reviews of performance in the area of enrollment and disenrollment to ensure compliance with requirements set forth in the MMC and MCOP provider agreements and in OAC.

Transition of Care Requirements for Members of an Existing MCOP

When the enrolling MCOP is informed by ODM, or its designee, of a member transitioning from an existing MCOP, the enrolling MCOP must follow the transition of care requirements required by ODM.

After an MCOP has been notified by ODM and/or another entity (e.g., waiver service coordinator, member, provider) of a member who is receiving home and community-based (HCBS) waiver services and whose enrollment is or may be terminating due to loss of MyCare Ohio eligibility, the MCOP must identify the reason for loss of eligibility and timely assist the member, as appropriate, with maintenance of MyCare Ohio eligibility.

Upon confirmation that MyCare Ohio eligibility will be terminated, during the last month of the individual's active membership, the MCOP must instruct the appropriate local Area Agency on Aging to end the MyCare Ohio waiver span in alignment with enrollment termination, and facilitate, as appropriate, referrals to programs (e.g., Medicaid waivers) and/or community resources that may assist the individual with continuation of long term services and supports. The MCOP must notify the member and all current waiver providers of the member's termination from MyCare Ohio, and as applicable, of any additional referral made to other HCBS Medicaid waivers. These referrals and notifications must be completed prior to the end of the month of termination, and when this is not possible, as soon as possible thereafter. If the member is found eligible for return to a Medicaid waiver program, the MCOP must provide the MyCare Ohio waiver service plan and any identified service issues or follow-up necessary to successfully transfer care to the waiver care management agency.

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

contacting the Ohio Medicaid Consumer Hotline to select a new MCOP as soon as possible to avoid any break in MyCare Ohio enrollment.

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

Change in Enrollment during an Inpatient Stay

When an MCP learns of a currently hospitalized member's intent to disenroll, the disenrolling MCP must notify the hospital/inpatient facility and treating providers as well as the enrolling MCP, if applicable, 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 cannot request 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 or ODM as applicable to facilitate discharge, transfer and service authorization.

When the enrolling MCP learns through the disenrolling MCP, through ODM 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 is required to contact the hospital or inpatient facility. The enrolling MCP must verify that it is responsible for all medically necessary Medicaid-covered services from the effective date of MCP membership, including professional charges related to the inpatient stay. The enrolling MCP must also inform the hospital/inpatient facility that the admitting/disenrolling MCP remains responsible for the hospital/inpatient facility charges through the date of discharge. ODM requires the enrolling MCP to 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 FFS was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the MCP must notify the hospital/inpatient facility and treating providers that the MCP is responsible for the professional charges effective on the date of enrollment, and must work to ensure that discharge planning provides continuity using MCP-contracted or authorized providers.

If ODM determines that an MCP has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act that are not specifically identified within the provider agreement, ODM may (1) require the MCP to permit any of its members to disenroll from the MCP without cause, or (2) suspend any further new member enrollments to the MCP, or both.

Grievance System

The guidelines for MMC and MCOP grievance systems are outlined in the provider agreements, and in OAC chapters 5160-26 and 5160-58, respectively.

General Requirements

MCPs must develop and implement written policies that ensure that members have and are informed of the right to file grievances, appeals, or state hearings. This includes the process by which members may file grievances with the plan to express their dissatisfaction with any aspect of the plan's or provider's operation or provision of health services, activities or behaviors; the process by which members may file appeals with the plan to request its review of an action, and the process by which members may access the state's hearing system through the Ohio Department of Job and Family Services (ODJFS).

MCPs are also required to notify providers of their right to participate in these processes on behalf of the provider's patients and to challenge the failure of the MCP to cover a specific service. Any provider acting on the member's behalf must have the member's written consent to file an appeal. The MCP is required to begin processing the appeal pending receipt of the written consent.

Notice of Action

An MCP "adverse benefit determination" is the denial or limited authorization of a requested service, including the type or level of service; a reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the plan; a denial, in whole or part, of payment for a service; the failure to provide services in a timely manner as specified in OAC rules 5160-26-03.1 and 5160-58-01.1 of the Administrative Code; failure to act within the resolution timeframes specified in OAC rules 5160-26-08.4 or 5160-58-08.4; or denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities, if applicable.

For MCOPs a denial of a request for a specific plan-contracted non-agency or participant-directed waiver services provider is also considered to be an "adverse benefit determination" on the part of the MCOP.

When an MCP adverse benefit determination has occurred or will occur, the MCP is required to provide the affected member(s) with a written notice of action (NOA) that meets the language and format requirements for member materials specified in OAC rule 5160-26-08.4 or 5160-58-08.4 and explains:

- The adverse benefit determination that the MCP has taken or intends to take;
- The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to all copies of all documents, records and other relevant determination information;
- The member's right to file an appeal to the MCP;
- Information related to exhausting the MCP appeal process;
- The member's right to request a state hearing through the state's hearing system upon exhausting the MCP appeal process;
- Procedures for exercising the member's rights to appeal the adverse benefit determination;
- Circumstances under which expedited resolution is available and how to request it;
- If applicable, the member's right to have benefits continue pending the appeal's resolution, how to request the continuation of benefits, and the circumstances under which the member may be required to pay for the cost of these services; and

- The date the notice was issued.

Additionally, the NOA must explain the availability of oral interpretation for any language, written translation availability for prevalent languages as applicable, and that alternative written formats may be available as needed. It should also include information on how to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP.

ODM, through OAC 5160-26-08.4 and OAC 5160-58-08.4, requires that MCPs include information around the procedures for members to file an appeal, a grievance or a state hearing request.

Provision of Grievance System Information

All MCPs are required to provide information to their contracting providers regarding grievance, appeal and state fair hearing procedures and time frames. This includes information regarding the member's right to file grievances and appeals and the requirements and time frames for filing; the MCP's toll-free telephone number to file oral grievances and appeals; the member's right to a state fair hearing; the requirements and time frames for requesting a hearing, and representation rules at a hearing; the availability of assistance from the MCP in filing any of these actions; the member's right to request continuation of benefits during an appeal or a state hearing and specification that at the discretion of ODM the member may be liable for the cost of any such continued benefits; and the provider's rights to participate in these processes on behalf of the provider's patients and to challenge the failure of the MCP to cover a specific service.

Additionally, each MCP must have a member services program that assists eligible individuals seeking information about MCP membership with information on filing grievances and appeals and obtaining information on state hearing rights.

Handling of Grievances and Appeals

ODM requires its contracting MCPs to give members all reasonable assistance in filing an appeal, a grievance, or a state hearing request including: explaining the MCP's process to be followed in resolving the member's appeal or grievance; completing forms and taking other procedural steps as outlined in OAC rule; and providing oral interpreter and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

ODM requires MCPs to acknowledge receipt of each appeal to the member filing the appeal. At a minimum, the acknowledgment must be made in the same manner that the appeal was filed. If an appeal is filed in writing, the MCP must provide written acknowledgment within three business days of the receipt of the appeal.

In addition, the MCP must ensure that the individuals who make decisions on appeals and grievances are individuals who: were neither involved in any previous levels of review or decision-making nor a subordinate of any such individual, and are health care professionals with the appropriate clinical expertise to treat the member's condition or disease if deciding an appeal of a denial based on lack of

medical necessity, a grievance regarding the denial of an expedited resolution of an appeal, or an appeal or grievance involving clinical issues.

The MCP must provide a member reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing, and inform the member of this opportunity sufficiently in advance of the resolution timeframe. Upon request, the member and/or the member's authorized representative must be provided, free of charge and sufficiently in advance of the resolution timeframe, the case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by the MCP, or at the direction of the MCP, in connection with the appeal of an adverse benefit determination. Additionally, the MCP must consider the member, member's authorized representative, or estate representative of a deceased member as parties to the appeal.

OAC allows a member, provider, or a member's authorized representative to file an appeal orally or in writing within sixty calendar days from the date that a NOA was mailed. When a filing is made orally, it must be followed with a written appeal. The MCP must immediately convert an oral appeal filing to a written appeal on behalf of the member, and consider the date of the oral appeal filing as the filing date.

Grievance and Appeals Resolution and Notification

For standard appeals, MCPs are required to review and resolve each appeal as expeditiously as the member's health condition requires, but the resolution timeframe must not exceed fifteen calendar days from the receipt of the appeal unless the resolution timeframe is extended as outlined in OAC rule 5160-26-08.4 or 5160-58-08.4.

A member or the MCP may request that the timeframe for an MCP to resolve a standard appeal be extended by up to fourteen calendar days. If the MCP requests an appeal extension, they must seek an extension from ODM prior to the expiration of the standard appeal resolution timeframe and the request must be supported by documentation that the extension is in the member's best interest. If ODM approves the extension, the MCP must make reasonable efforts to provide the member prompt oral notification of the extension, and within two calendar days, provide the member written notice of the reason for the extension and the date by which a decision will be made. ODM requires MCPs to maintain the documentation associated with any extension request.

The MCP must provide written notice of the appeal's resolution to the member, and to the member's authorized representative if applicable. At a minimum, the written notice must include the resolution decision and date of the resolution. For appeal decisions not resolved wholly in the member's favor, the written notice to the member must also include the following information:

- The right to request a state hearing through the state's hearing system;
- How to request a state hearing and, if applicable, information about the member's right to continue to receive benefits pending a state hearing, how to request the continuation of benefits, and an explanation that if the MCP's adverse benefit determination is upheld at the state hearing, the member may be liable for the cost of any continued benefits;
- Oral interpretation is available for any language;
- Written translation is available in prevalent non-English languages as applicable

- Written alternative formats may be available as needed; and
- Explain how to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP.

When an appeal resolution is decided in favor of the member, the MCP must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the appeal resolution date if the services were not furnished while the appeal was pending. The MCP must also pay for the disputed services if the member received the services while the appeal was pending.

Expedited Appeal Resolution

In accordance with OAC rules, MCPs are required to establish and maintain an expedited review process to resolve appeals when the member requests and the MCP determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that the timeframe for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

In utilizing an expedited appeal process, the MCP must not only comply with the standard appeal processes specified in OAC rule, but is also required to:

- Determine whether to expedite the appeal resolution within one business day of the appeal request;
- Make reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not;
- Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing;
- Resolve the appeal as expeditiously as the member's health condition requires, but the resolution timeframe must not exceed seventy-two hours from the date the MCP received the appeal unless the resolution timeframe is extended per OAC rules;
- Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification; and
- Ensure punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

If the MCP denies the request for expedited resolution of an appeal, the MCP is required to transfer the appeal to the standard resolution timeframe of fifteen calendar days from the date the appeal was received unless the resolution timeframe is extended per OAC rules. The MCP is also required to make reasonable efforts to provide the member prompt oral notification of the decision not to expedite, and within two calendar days of the receipt of the appeal, provide the member written notice of the reason for the denial, including information that the member can grieve the decision.

Recordkeeping and Reporting Requirements

MCPs are required to maintain records of all appeals and grievances, including resolutions, for a period of ten years, and the records must be made available upon request to ODM and the Medicaid Fraud Control Unit. Each MCP is also required to assign a key staff person to be responsible for the logging and reporting of appeals and grievances and assuring that the grievance system is in accordance with OAC rules.

ODM uses state hearing notifications and requests along with member appeals, grievances, and complaints; consumer satisfaction surveys; state hearing notifications/requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures to monitor access to services.

Continuation of Benefits

The MCP NOA must include information regarding how to request that benefits be continued when an appeal resolution is pending, as well as the circumstances under which the member may be required to pay for services.

Unless a member requests that previously authorized benefits not be continued, the MCP is required to continue a member's benefits when all the following conditions are met:

- The member files an appeal within fifteen calendar days of the MCP issuing the NOA;
- The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services;
- The services were ordered by an authorized provider; and
- The authorization period has not expired.

If the MCP continues or reinstates the member's benefits while the appeal or state hearing is pending, the benefits must be continued until either the member withdraws the appeal or state hearing request, the member fails to request a state hearing within fifteen days after the MCP issues an adverse appeal resolution, or the Bureau of State Hearings issues a state hearing decision upholding the reductions, suspension or termination of services.

If the final resolution of the appeal or state hearing upholds the MCP's original adverse benefit determination, at the discretion of ODM, the MCP may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.

Failure to comply with appeal, grievance, or state hearing requirements, including the failure to notify a member of his or her right to a state hearing when the MCP proposes to deny, reduce, suspend or terminate a Medicaid-covered service may result in a plan accumulating points towards receiving a financial sanction. ODM retains the right to use its discretion to determine and apply the most appropriate sanction based on the severity of the noncompliance, a pattern of repeated noncompliance, and number of beneficiaries affected.

Sub-contractual Relationships and Delegation

MCPs that delegate to First Tier, Downstream and Related Entities (FDRs), must ensure that they have an arrangement with a party to perform administrative services as defined below on the MCP's behalf.

Unless otherwise specified by ODM, administrative services include: Care Management, Marketing, Utilization Management, Quality Improvement, Enrollment, Disenrollment, Membership Functions, Claims Administration, Licensing and Credentialing, Provider Network Management, and Coordination of Benefits. Additionally, before the MCP enters into an arrangement with an FDR to perform any administrative function not listed that could impact a member's safety, welfare or access to Medicaid-covered services, the MCP must contact ODM to request a determination of whether or not the function should be included as an administrative service that complies with the provisions listed in the provider agreement.

Upon request, MCPs are required disclose to ODM all financial terms and arrangements for payment of any kind that apply between the MCP, or the MCP's FDR, and any provider of a Medicaid service.

MCPs must ensure that all written arrangements with FDRs include the provisions specified in the provider agreements with ODM.

Each MCP must oversee and be accountable for any delegated function or responsibilities. The MCP is responsible for ensuring all the MCP's activities and obligations are performed in accordance with OAC, the applicable Medicaid Managed Care or MyCare Ohio provider agreement, and all applicable federal, state, and local regulations.

Information regarding new, changes to, or termination of FDR arrangements must be reported to ODM no less than fifteen (15) days prior to it taking effect.

MCPs are ultimately responsible for meeting all contractual obligations under the MCP's provider agreement with ODM. MCPs must:

- Ensure that the performance of FDRs is monitored on an ongoing basis to identify any deficiencies or areas for improvement;
- Impose corrective action for the FDRs as necessary; and
- Have policies and procedures that ensure there is no disruption in meeting their contractual obligations should the FDR or MCP terminate the arrangement.

Agreements between MCPs and FDRs must include:

- Language that provides for revocation of the FDRs provision of administrative services or specifies other remedies, as applicable, if ODM or the MCP determine that parties have not performed satisfactorily or the arrangement is not in the best interest of the MCP's members; and
- A provision that the arrangement is governed by, and construed in accordance with all applicable state or federal laws, regulations and contractual obligations of the MCP. The arrangement must

be automatically amended to conform to any changes in laws, regulations and contractual obligations without the necessity for written execution.

Delegated entities are bound by the same standards of confidentiality that apply to the ODM and the state of Ohio as described in OAC rule 5160:1-1-51.1 and 45 CFR Parts 160 and 164, including standards for unauthorized uses or disclosures of protected health information (PHI). Delegated entities are required to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.

Delegated entities are required to agree that their applicable facilities and records will be open to inspection by the MCP, ODM or its designee, or other entities as specified in OAC rule 5160-26-06.

Because the MCP is ultimately responsible for meeting program requirements, the ODM will only discuss MCP issues with the MCP's subcontractors when the MCP is also participating in the discussion, or when the MCP grants ODM permission to do so. MCP delegated entities should communicate with ODM when the MCP is participating, or when the MCP grants authorization to communicate directly with ODM.

Intermediate Sanctions

ODM's provider agreements with MCPs include established intermediate sanctions that may be imposed if an MCP fails to comply with specified requirements.

The State may impose sanctions to address MCP noncompliance with quality of care measures and program requirements. Sanctions include: corrective action plans, performance improvement projects, quality improvement directives, reductions in auto-enrollment percentages, new enrollment freezes, and both refundable and non-refundable monetary sanctions. When penalties are assessed, ODM works with the plan to implement quality improvement strategies to advance performance levels. Serious and/or continued deficiencies may result in an enrollment freeze, imposition of temporary management, and/or termination or non-renewal of an MCP contract.

Intermediate sanctions are also used to address identified quality of care problems. ODM evaluates MCP performance in key areas (i.e., access, clinical quality, consumer satisfaction) through the use of established Quality Measures and Standards. The selected measures align with specific priorities, goals, and/or focus areas of the ODM Quality Strategy. Specific measures and standards are used to determine MCP performance incentives, while others are used to determine MCP noncompliance sanctions. All of the measures utilized for performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ), widely used for evaluation of Medicaid and/or managed care industry data.

When an MMCP does not meet the minimum performance standard for an incentive measure, a quality improvement project (QIP) is initiated to address the population stream impacted. The requirements for these QIPs can be found in Appendix E (QI Project Planning Guidance).

Compliance Assessment System (CAS)

If the MCP is found to have violated the provider agreement, or any other applicable law, rule or regulation, sanctions are imposed as set forth by ODM's Compliance Assessment System.

The content of ODM's Compliance Assessment System (CAS) is outlined in the provider agreement with each MCP, and is designed to improve the quality of each managed care plan's performance by addressing identified failures in meeting program requirements. A MMCP may be requested to submit a Remediation Plan which is a structured activity or process implemented to improve identified deficiencies related to compliance with program requirements. Failure to comply with or meet the requirements of a Remediation Plan may result in the imposition of progressive sanctions /remedial actions.

The CAS assesses progressive remedies with specified values (e.g., points, monetary sanctions, etc.) assigned for certain documented failures in satisfying the deliverables required by OAC rules and/or the provider agreement. The CAS focuses on clearly identifiable deliverables, and sanctions or remedial actions are only assessed in documented and verified instances of noncompliance. Regardless of whether ODM imposes a sanction, the MCP is required to initiate corrective action for any MCP program violations or deficiencies as soon as they are identified by the MCP or ODM.

ODM may impose sanctions/remedial actions, including but not limited to, the items listed below:

- *Corrective Action Plans (CAPs)*: a structured activity, process or quality improvement initiative implemented by the MCP to improve identified operational and clinical quality deficiencies. MCPs may be required to develop CAPs for any instance of noncompliance with applicable rules, regulations or contractual requirements. All CAPs requiring ongoing activity on the part of an MMCP to ensure its compliance with a program requirement will remain in effect until the MMCP has provided sufficient evidence that it has fulfilled the requirements of the CAP to the satisfaction of ODM with the exception of a CAP requiring implementation of a quality improvement initiative. All CAPs requiring implementation of quality improvement initiatives will remain in effect for at least twelve months from the date of implementation.
- *Points*: Points accumulate over a rolling 12-month schedule and are assessed based on the severity of the violation (e.g., impeding access to care, impairing ability for a member to receive correct information, etc.), and points older than 12 months old will expire. No points are assigned if an MCP is able to document that the violation was due to unforeseeable, precipitating circumstances beyond its control (e.g. construction crew severing a phone line, a lightning strike disabling a computer system, etc.).
- *Financial Sanctions due to accumulated points*: Financial sanctions are assessed based on the number of points an MCP has accumulated during a rolling 12-month period. Refundable or nonrefundable sanctions may be assessed as a penalty separate to, or in combination with, other sanctions/remedial actions.
- *Progressive Sanctions based on Accumulated Points*: progressive sanctions will be based on the number of points accumulated at the time of the most recent incident. CAPs and other sanctions may also be imposed in addition to the financial sanctions listed below. The designated financial sanction amount will be assessed when the number of accumulated points falls within the ranges specified below:

<u>0 -15 Points</u>	<u>CAP + No financial sanction</u>
<u>16-25 Points</u>	<u>CAP + \$5,000 financial sanction</u>
<u>26-50 Points</u>	<u>CAP + \$10,000 financial sanction</u>
<u>51-70 Points</u>	<u>CAP + \$20,000 financial sanction</u>

71-100 Points CAP + \$30,000 financial sanction
100+ Points Proposed Agreement Termination

- *Specific pre-determined sanctions:* There are specific pre-determined sanctions for the following:
 - Adequate network-minimum provider panel requirements
 - Adequate provider panel time and distance requirements
 - Network performance baseline measure
 - Late submissions
 - Noncompliance with claims adjudication requirements
 - Noncompliance with financial performance measures or the submission of financial statements.
 - Noncompliance with medical loss ratio (MLR requirements for adult extension population
 - Noncompliance with reinsurance requirements
 - Noncompliance with prompt payment
 - Noncompliance with claims payment systemic errors (CPSEs)
 - Noncompliance with clinical laboratory improvement amendments (CLIA)
 - Noncompliance with abortion and sterilization hysterectomy requirements
 - Refusal to comply with program requirements
 - Data quality submission requirements and measures
 - Quality measures
 - Quality care
 - Noncompliance with provision of transportation services
 - Noncompliance with behavioral health carve-in testing
- *Quality Improvement Directives:* Quality improvement directives are general instructions that direct the MCP to implement a quality improvement initiative to improve identified administrative or clinical deficiencies.
- *Combined or Progressive remedies:* Remedies may be combined or made progressively greater in order to address systemic problems or if there are a number of repeated instances of noncompliance with the same program requirement.
- *New member enrollment freezes:* The MCP may be prohibited from receiving new membership through consumer initiated selection or assignment.

- *Reduction of assignments:* The number of assignments an MCP receives may be reduced in order to assure program stability within a region or if the MCP lacks sufficient capacity to meet the needs of the increased volume in membership.
- *Termination, amendment or non-renewal of the provider agreement*

The CAS has successfully allowed ODM to monitor the plans' compliance with contract requirements and improve deficiencies in clinical and/or administrative operations in order to assure that high quality health care is delivered to Medicaid managed care plan members.

Measurement & Improvement Standards

Practice Guidelines

All MCPs must adopt practice guidelines and disseminate the guidelines to all affected providers and to members or pending members if they are requested. These guidelines must: be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; consider the needs of the MCP's members; be adopted in consultation with contracting health care professionals; and be reviewed and updated periodically, as appropriate. MCPs are to disseminate the guidelines to all affected providers and upon request, to enrollees and potential enrollees. Moreover, decisions regarding utilization management, enrollee education, and coverage of services are to be consistent with the plan's guidelines.

A description of how each MCP meets these requirements is included as part of their QAPI submission (see Appendix C). MCP QAPIs are used not only for monitoring MCP compliance with ODM requirements, but also inform the evaluation of ODM's quality program and assist ODM in identifying areas needing improvement. More information on the QAPI program can be found in Section V, Improvement and Interventions.

IV. Delivery System Reforms

Ohio has recently implemented several delivery system reforms, including: extending Medicaid eligibility so more Ohioans have healthcare coverage, facilitating enrollment, expanding coordinated care, and reforming payment structures to focus on value.

Extending Medicaid Eligibility

Group VIII

The Affordable Care Act of 2010 provided states with the option of expanding Medicaid to low-income, childless adults who do not have a disability. This is an eligibility group that cuts across all of ODM's population streams. Ohio Medicaid received approval for its Alternative Benefit Plan for this population in December of 2013 with an effective date of January 1, 2014. By the close of June 2014, 285,533 Ohio residents were successfully enrolled for coverage. Most of these newly eligible individuals are served through the managed care delivery system. The quality of, access to, and satisfaction with care of this population is monitored using the same quality metrics that are used throughout the Ohio Medicaid Managed Care program (see Appendices A and B). Evaluation of the expansion revealed that many of these individuals were able to receive care for the first time and that receiving this care allowed the pursuit and maintenance of employment.³

Streamlining Enrollment

Presumptive Eligibility (PE)

In July of 2013, ODM began providing uninsured residents with the opportunity to receive immediate health care services through Medicaid if they are presumed to be eligible as a result of an initial, simplified determination based on the resident's self-declared statements. Individuals who qualify through PE will then be provided with the information to apply for full Medicaid coverage.

The following entity types may determine presumptive eligibility: county departments of job and family services (CDJFSs), hospitals, departments of youth services (DYS), federally qualified health centers (FQHCs) and FQHC look-alikes, local health departments, and women infant and children (WIC) clinics.

Presumptive eligibility allows individuals with immediate needs to obtain services quickly. A full application process is needed to maintain eligibility after the presumptive eligibility period closes.

Ohio's Disability Determination Redesign

While the majority of states have a single disability determination system, for decades Ohioans have had to navigate two separate processes (state and federal) to be determined disabled for the purposes of Medicaid eligibility. In August of 2016, Ohio moved to a single disability system which makes it easier for individuals to apply for and maintain healthcare coverage. By increasing the federal poverty limit cutoff from 64% to 75%, the new disability determination system also results in more people having full Medicaid coverage. Individuals also no longer have to spend-down their income on a monthly basis, making coordination of care much easier.

³The Ohio Department of Medicaid. *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly*. 2016. Retrieved from: <http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf>

Ohio recently expanded the populations who are enrolled in Managed Care. Beginning in January of 2017, all eligible children in custodial care arrangements are mandatorily enrolled in managed care. Additionally, children with medical handicaps are be mandatorily enrolled. Individuals on DD waivers may choose to be voluntarily enrolled into managed care.

Coordinating Care

MyCare Ohio Program Dual-Eligible Demonstration

Historically, Medicare and Medicaid design and management have had little connection to one another, and have lacked a single point of accountability. Additionally, long-term services and supports (LTSS), behavioral health services and physical health services used by the dually eligible were poorly coordinated, resulting in a diminished quality of care for people within the chronic care and behavioral health population streams. With this in mind, in July of 2013, Ohio Medicaid applied for a concurrent 1915b/c waiver to allow dually-eligible individuals to receive their care through the Managed Care delivery system while waiving the state-wideness requirement. At the time of Ohio's application, more than 182,000 Ohioans were enrolled in both Medicare and Medicaid, accounting for nine percent of total Ohio Medicaid enrollment and almost 30 percent of total Medicaid spending.

Approval of the concurrent waiver allowed Ohio to create a five-year Integrated Care Delivery System (ICDS) demonstration through the Centers for Medicare and Medicaid Innovation (CMMI) which offers a new approach to meeting the needs of dually eligible individuals by using a capitated managed care model that oversees the delivery of all medically necessary services. Ohio named this program the MyCare Ohio.

The MyCare Ohio approach is centered on the individual and incorporates a care team to effectively coordinate care based on an individual's specific needs. This care team includes: the individual, the individual's family/caregiver, the MyCare Ohio care manager, the waiver service coordinator (if appropriate), the primary care provider, specialists, and other providers as applicable. This model supports the goals of integrating patient and family care preferences, and clear communication, accessible and optimized care. The five MyCare Ohio plans (MCOPs) are required to integrate physical, behavioral, and long-term care into one coordinated benefit package for individuals enrolled in both Medicare and Medicaid. The benefit package includes all benefits available through the traditional Medicare and Medicaid programs, including long-term care services and supports and behavioral health services. In addition, the MCOPs may elect to include additional services in their benefit packages.

MyCare Ohio was launched in Northeast Ohio on May 1, 2014. The demonstration program is now serving over 100,000 residents in 29 participating counties.

Managed Care Day One

In January 2018, for individuals that fall into a mandatory managed care enrollment category, ODM began assigning individuals to an MMC plan effective on the first day of the month in which they are found Medicaid eligible. Once enrolled in managed care, individuals have the option to switch plans within the first 90 days of enrollment if they are not satisfied with the plan to which they are assigned. Managed care plans must mail member materials and Medicaid cards within specific timeframes upon receipt of the daily file notifying them of the newly enrolled member.

Assignment of Managed Care on day one impacts Aged, Blind or Disabled (ABD) and the Covered Families and Children (CFC) populations. Populations that are excluded from Managed Care Day One include: MyCare enrollees, individuals participating in the pre-release program, foster care and deemed newborns.

Behavioral Health Redesign

The Medicaid behavioral health population stream in Ohio represents 27 percent of Medicaid members. For several decades, behavioral health has been “carved out” of traditional managed care and services have been provided through a FFS delivery model. Over the past six years, Ohio has redesigned the Medicaid behavioral health services delivery system and benefit package in four stages: elevation, expansion, modernization and integration.

During the first stage of behavioral services delivery system redesign, completed in 2012, the financing of Medicaid behavioral health services was elevated from the county to state. Medicaid expansion in 2014 allowed over 500,000 residents with behavioral health needs to begin receiving needed services. In SFY 2016, Ohio began the process of modernizing the behavioral health benefit package to align with national standards and to expand services to those in need, including expanded treatment for substance use disorder in both outpatient and inpatient settings. The new behavioral health benefit package became available on January 1, 2018.

Behavioral health services will be integrated into Ohio’s current Medicaid managed care plan contracts on July 1, 2018 (making the services “carved-in” to managed care). Provider organizations in the new network include community behavioral health organizations, inpatient hospitals, clinics, and specialty practitioners.

This carve-in of behavioral health services supports ODM’s commitment to developing a healthcare market where payment is consistently and increasingly designed to reflect and improve the effectiveness and efficiency of care delivery and where Medicaid insured individuals are actively engaged in managing their own health, including selection of providers and value-based services.

Value-based Payment Models

Ohio’s goal is to have at least 80% of Ohio’s population receiving services through a value-based payment model (combination of episodes-and population-based payment) within five years. Several strategies are currently being implemented to assist with this goal. Examples include:

- Paying (or withholding payment from) providers based on performance,
- Designing approaches to cut waste while preserving quality,
- Designing payments to encourage adherence to clinical guidelines (such as not paying for early elective deliveries), and
- Implementing payment strategies to reduce unwarranted price variation.

The Ohio Department of Medicaid has joined the Governor's Office of Health Transformation to engage public and private sector partners in designing a new health care delivery payment system that rewards the value of services – not the volume. Ohio's State Innovation Model (SIM) grant centers on testing payment models that increase access to comprehensive primary care and support retrospective episode-based payments for acute medical events.

Ohio's Comprehensive Primary Care (CPC) Program

Ohio CPC is an investment in primary care infrastructure intended to support improved population health outcomes. CPC is a patient-centered medical home program, which is a team-based care delivery model led by a primary care practice that comprehensively manages a patient's health needs.

The goal of the program is to empower practices to deliver the best care possible to their patients, improving quality of care and lowering costs. Although most medical costs occur outside of a primary care practice, primary care practitioners are able to guide many decisions that impact those broader costs, improving cost efficiency and care quality.

Initial piloting of the CPC program provided information needed to assist members of the design team (providers, payers and patients) in making decisions regarding the Medicaid payment model, attribution methodology, and quality metrics.

Beginning in the fall of 2016, select practices were invited to enroll in the CPC program. New practices are able to enroll in the program on an annual basis during the fall open enrollment period. Practices only need to enroll once; enrollment will roll over from year to year. As of February, 2018 approximately 170 clinical practices were participating in the CPC program, from all over the state and which collectively are serving an estimated 30% of Ohio's Medicaid population.

There are three types of requirements that practices must meet in order to receive payments through the CPC program: activity requirements, clinical quality metrics, and efficiency metrics. These requirements essentially define the core PCMH functions. Practices must meet all activity requirements, 50% of applicable quality metrics, and 50% of applicable efficiency metrics in order to be eligible for payment.

The performance period and reporting for Ohio CPC begins in January of the year following provider enrollment in the program. Providers receive quarterly progress reports and annual performance reports.

The PCMH model will be available statewide in 2019 and subsequent to the timeframe when Medicaid behavioral health benefits are carved into managed care. The overall goal is to enhance the state's primary care capacity in a way that fosters the integration of behavioral health into traditional medical practice.

Managed care plans are supporting ODM's efforts to promote the CPC model by assisting providers with obtaining certification as a PCMH by a nationally recognized accreditation organization, creating electronic member profiles for use by providers in managing patients, and providing assistance to providers with practice transformation.

Episode-based Payments

In episode-based payments, a Principal Accountable Provider (PAP) is identified and is eligible to benefit financially by keeping the costs of care low and the quality of care high. For each episode, patients seek care as usual and providers continue to submit claims as they have in the past. The difference is that after the performance year, the expenditures attributed to the PAP are compared to target levels. PAPs are then eligible to participate in shared savings based on how they compare to their peers.

In designing the program, ODM involved stakeholders through the use of clinical advisory groups to discuss of episode development.

Medicaid FFS, all five MCPs and participating commercial plans began reporting on six episodes of care in March of 2015: Perinatal, asthma exacerbation, COPD, total joint replacement, non-acute percutaneous intervention, and acute percutaneous interventions. These episodes address multiple population streams, including: women's health, chronic conditions, and healthy populations. The reports compare providers to their peers and against absolute performance measures indicating acceptable and commendable levels of expenditures. In 2016, the first performance year began for three of the initial episodes (asthma exacerbation, COPD and perinatal).

After twelve months of quarterly reporting, incentive payments based on the previous 12 month period of outcomes began. Incentive payments are based on how providers perform based on these targets. Providers may either: share savings if average costs are below commendable levels and quality targets are met; pay part of the cost if average costs are above the acceptable level; or see no change in pay, if average costs are between commendable and acceptable levels.

Seven additional episodes: appendectomy, cholecystectomy, colonoscopy, esophagogastroduodenoscopy, gastrointestinal bleed, upper respiratory infection and urinary tract infection were added later in 2015. The reporting period for these measures began in 2016 and the first performance year was 2017. The third wave of episode design is currently in process, with the reporting period targeted for 2017 and the first performance year beginning in 2018.

In 2018, there will be a total of 43 episodes that have been defined and launched across MCPs; nine of these are linked to payment and more are planned in 2019. Reporting on specific measures related to opioid prescribing patterns has been instituted for more than ten separate episodes.

Both of these models aim to achieve better health, better care, and cost savings through improvement, while laying the foundation for a healthcare system founded on quality of health outcomes, rather than quantity of treatments.

The Ohio Department of Medicaid is working closely with payer partners, including all Medicaid managed care plans (Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Health Care, and UnitedHealthcare Community Plan) and four commercial payers (Aetna, Anthem, Medical Mutual of Ohio, and UnitedHealthCare) to contribute to the success of these models.

ODM's delivery system reforms have facilitated access to health insurance coverage for Ohioans, allowing them to get the coordinated care needed to prevent the development or intensification of chronic conditions and allowing many to return to work. These changes, along with a redesign of Ohio Medicaid's care management, quality improvement program and incentive structure, discussed below, are designed to drive population health improvement by increasing access, coordination of care and responsiveness while prioritizing value over volume of care.

V. Improvements and Interventions

Transforming ODM's Managed Care Plan Quality Improvement Program

In 2017, ODM refined the MCP's quality improvement program to better align with the population-based health approach and ODM's delivery system reforms. The intentional shift to a value based purchasing role recognizes that MCPs are required to play a different role (purchaser of value vs. a payer of claims) and focus efforts in a new way (effective programs versus compliance oriented programs). To that end, ODM relieved Managed Care Plans of detailed care management requirements so they could shift resources to effective population health strategies. ODM expects managed care plans to shift resources to proven quality improvement strategies and by supporting ODM's value based purchasing initiatives. Three components of the MCPs' quality improvement program were revised for a January 1, 2018 effective date: population health management program, MCP quality improvement programs, and incentives to promote MCP performance.

Population Health Management

In 2016, ODM shifted focus from care management to population health management strategies and emphasized better integration of clinical partners' efforts to improve health outcomes. For the 2018 update, ODM reinforced population health management as the primary driver of resource allocation, infrastructure and processes to improve health outcomes. Components of the population health program are as follows:

- Identification – Use of assessments, claims, and supplemental data sources to identify clinical cohorts that align with ODM's five population streams (women's health, chronic conditions, behavioral health, and healthy children & adults).
- Prioritization – Assign a risk level considering clinical conditions, social determinants, geography, etc. for the purpose of targeting interventions and allocating resources based on member's needs.
- Programming – Comprehensive offering of services tailored to population stream and risk level. Examples include medical homes, disease management, health and wellness programs, enhanced maternal care, care management, community workers, etc.
- Continuous quality improvement – Assessment and improvement of specialized programming for each group identified by the MCP's population health management strategy.

Each MCP is required to develop a model of care for ODM review and approval that describes how specialized services and resources are tailored to the MCP's population. This new approach was rolled out in Medicaid Managed Care and MyCare in 2016 and 2017, respectively, and continues to be implemented in 2018.

Care Management

Care management is a critical component of a well-designed population health management program driven by actionable clinical, financial, and operational data from multiple delivery systems that can be used to improve quality of care, patient experience, and reduce inappropriate costs of care. Attributes

of a high performing care management system include: timely, proactively planned communication and action; an emphasis on cross-continuum collaborations and relationships; comprehensive consideration of physical, behavioral, and social determinants of health; and promotion of members' self-care and independence. In addition, highly functioning care management is person and family centered and works in congruence with and in support of primary care physicians in an effort to remove duplication and focus on optimal health and wellness.

In 2017, ODM redesigned the care management program to extend greater flexibility to the MCPs with the design and implementation of their management. Central to the program redesign was a desire to focus on effectiveness versus compliance oriented care management programs. Requirements that were overly prescriptive were eliminated in favor of specifying what care management should look like and not how to deliver care management services. Assessment requirements were streamlined; staffing ratios were eliminated with flexibility granted to staff individual cases based on needs; required face to face contacts were replaced with the focus being on MCP development of a meaningful communication plan based on member's needs; and elimination of requirements to care manage a certain percentage of the MCP's overall membership. To further assist with this transformation, the MMCP supports, and connects members to comprehensive primary care (CPC), Ohio's patient-centered medical home (PCMH) model and one of the initiatives to ensure that Ohio's Medicaid Managed Care program is paying for value through emphasis on quality and care coordination rather than volume of care.

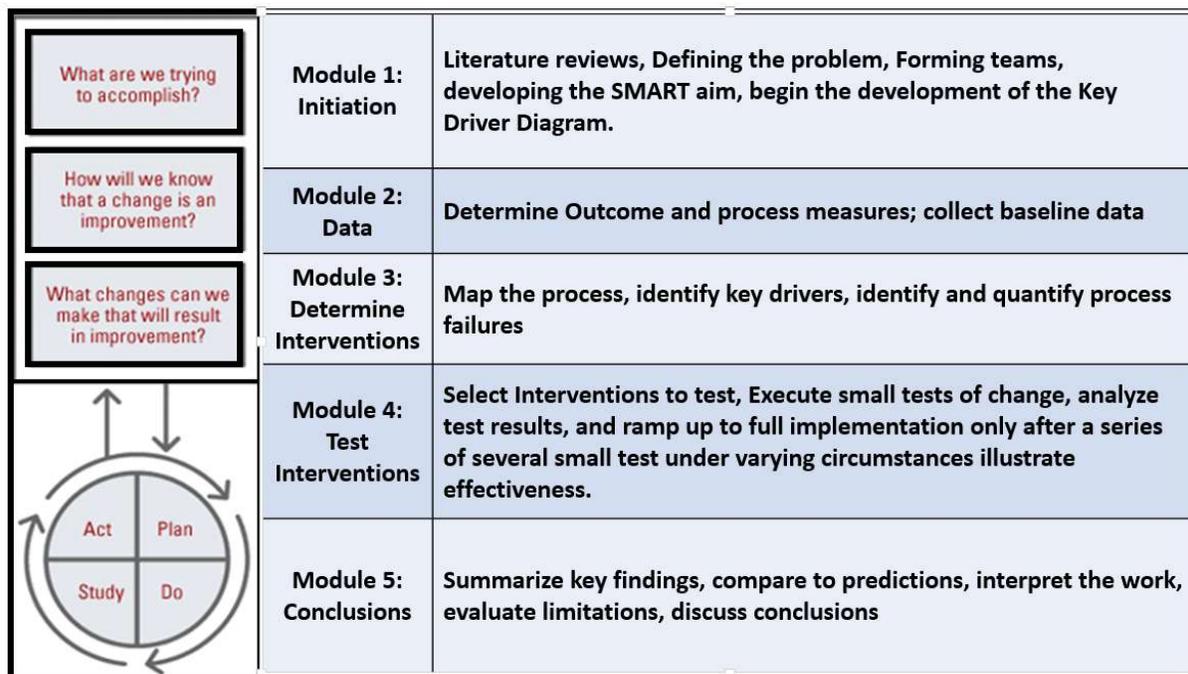
MCP Quality Improvement Programs

Building a Culture of Quality Improvement

The experience and training gained through participation in the Adult Medicaid Quality Grant assisted Ohio in restructuring improvement projects to incorporate rapid cycle quality improvement science as used by the Institute for Healthcare Improvement. Using this approach allows MCP alignment with the improvement tools and methods used by Ohio's medical provider community, fostering a common improvement culture and a coordinated approach to improving outcomes.

Aligning with Quality Improvement Science. In October of 2014, Ohio Department of Medicaid (ODM) received permission from the Centers for Medicare and Medicaid (CMS) to align its Performance Improvement Project (PIP) process with the Model for Improvement developed by Associates in Process Improvement and popularized by the Institute for Healthcare Improvement (IHI) shown in Figure 7 below.

Figure 7. Model for Improvement and Alignment with EQRO Module Validation



In 2015, ODM began working with MCP QI teams to apply this framework and build QI capacity within the context of the Progesterone Improvement Project. By standardizing communication regarding notification of pregnancy and patient needs across all five MCPs and FFS, as well as bringing together nontraditional partners such as the Board of Pharmacy, MCP contracted home health agencies and specialty pharmacies, and county eligibility, to help maintain patients’ Medicaid coverage and reduce barriers to timely progesterone administration, ODM was able to achieve noticeable improvements in preterm birth rates⁴.

Expanding QI Science Methods to MyCare Ohio Improvement Projects. Based on this success, ODM requested permission to expand the use of the Model for Improvement to MyCare plans. In October of 2017, CMS granted ODM permission to align MyCare Ohio and Medicaid’s approach to quality improvement science so that improvements could be realized more quickly and a common quality improvement culture across all Medicaid and MyCare plans could be more efficiently and effectively developed.

However, with staff turnover and as new projects began, it quickly became apparent that the training received by MCP teams as part of the progesterone project had not been transferred to others within

⁴ Iams JD, Applegate MS, Marcotte MP, Rome M, Krew MA, Bailit JL, Kaplan HC, Poteet J, Nance M, McKenna DS, Walker HC, Nobbe J, Prasad L, Macaluso M, Lannon C. A Statewide Progesterone Promotion Program in Ohio. *Obstet Gynecol.* 2017 Feb;129(2):337-346.

the MCP organizations, as each of the six MCPs used different QI terminology and methods across their programs. Furthermore, leadership support for QI projects varied and staff competency varied greatly.

In response to these observations, as well as the relatively static nature of improvement measures, ODM augmented its approach to quality by focusing on building a common quality improvement culture across our MCP partner organizations.

Building QI Capacity. To provide guidance to the MCPs for building a culture of quality and to standardize Ohio Medicaid's quality improvement approach, the Medicaid and MyCare provider agreements were updated in 2018 to focus on the QI program structure and capacity building. Requirements include: defining the roles and responsibilities of MCPs' Senior QI leadership teams, outlining QI initiative staffing and responsibilities, detailing training requirements, and requiring that all MCPs develop a process for spreading the use of these concepts and tools throughout their organizations.

To assist the MCPs in this cultural shift, ODM has contracted with Cincinnati Children's Hospital's James M. Anderson Center for Health Systems Excellence (Anderson Center), a national leader in QI science with proven success. The Anderson Center has developed training curricula and materials for teaching the Model for Improvement and use of associated improvement tools to MCP QI Leadership Teams and Executive Sponsors (including CEOs and medical directors), as well as individual quality improvement project teams. These training materials are made available for download to assist the MCPs in spreading the concepts and usage of the tools throughout their organizations. ODM has also engaged the Anderson Center to assist ODM in developing frame works for building the capacity of quality improvement coaches and performance assessment staff to assist MCPs in in applying the improvement science model, tools, and techniques to increase their effectiveness in improving population health.

These changes are intended to assist the MCPs in moving from payers of claims to purchasers of value, focusing on achieving quality strategy goals instead of complying with program requirements, and supporting ODM's value-based purchasing initiatives.

Quality Assessment and Performance Improvement (QAPI) Program

As required by 42 CFR 438.330, MCPs are required to have ongoing quality assessment and performance improvement (QAPI) programs that reflect a systematic approach for assessing and improving the quality of care. ODM has restructured this tool to assess MCP progress in building quality improvement capacity. Each of the provider agreement requirements—developing a QI leadership team, obtaining training in quality improvement science concepts, tools and methods, and building QI capacity—are built into the annual reporting framework of the QAPI.

As part of the yearly submission, MCPs must evaluate the impact and effectiveness of their QAPI program.

The QAPI program description which MCPs submit annually to ODM includes the following elements:

- Program structure and accountability

- Mechanisms to detect both under- and over-utilization of healthcare services;
- Mechanisms to detect the quality and appropriateness of care furnished to enrollees with special healthcare needs;
- A Quality Measurement and Assessment Improvement Strategy;
- Efforts to address health disparities and take cultural differences into account;
- The incorporation and communication of evidence-based clinical practice guidelines;
- Improvement Projects that address clinical and non-clinical areas for improvement using Quality Improvement Science techniques in order to achieve, through frequent measurement and intervention, improvements in health outcomes, quality of life, and provider and consumer satisfaction. MCPs are required to report on the full portfolio of improvement projects not just those required by ODM and/or CMS; and
- The incorporation of evaluation outcomes and knowledge gained into future improvement initiatives.

The QAPI guidance document (Appendix C) is used by the MCPs when submitting information about their QAPI programs is regularly reviewed and revised to align with federal regulations, add specificity and clarity regarding the expected content, and to reduce duplication by more closely aligning with NCQA and other requirements.

As a primary tool for documenting and assessing MCP quality programs, the MCPs' QAPIs, along with performance measure data, improvement project results, and assessments and technical reports from Ohio's EQRO, are used to facilitate ODM's annual review of the impact and effectiveness of the managed care quality strategy and to identify areas that need additional focus.

Those areas identified as needing additional focus result in improvement initiatives. These initiatives include focused improvement projects, requiring the MCPs to apply quality improvement science tools and methods.

Improvement Initiatives

ODM requires MCPs to actively participate in both federally-required improvement projects and quality improvement projects reflecting state efforts to improve quality of care and outcomes. As required by the MMC and MCOP provider agreements, active participation includes: attending meetings, assigning subject matter experts and leadership support to improvement efforts; responding promptly to data requests; dedicating resources to implement quality improvement interventions; establishing internal mechanisms to frequently communicate improvement project status updates and results to the MCP's CEO, Medical Director, and the Quality Improvement Director; and maintaining regular communication with ODM or EQRO staff.

The topic choice for ODM required improvement projects is tied to the state quality strategy and focuses on one of the five population health streams (women's health, adults and children with chronic conditions, adults and children with behavioral health needs, healthy children and healthy adults). Topics addressing disparities in health outcomes are prioritized. Many of these projects involve active

collaboration with other state agencies (e.g., ODH, MHAS), state quality collaborative groups (e.g., OPQC),

Access to Care Initiatives

Medicaid Pre-Release Enrollment Program. In September 2014, the Ohio Department of Rehabilitation and Corrections (DRC) and the Ohio Department of Medicaid joined forces to establish a program to facilitate Medicaid enrollment and selection of a managed care plan 90 days prior to the release of an incarcerated individual. For individuals with complex health care needs, there is an in-reach completed by MCP care managers who assist with the development of a transition plan to assure successful integration to the community.

This partnership created a continuum of healthcare within the criminal justice system in Ohio by connecting individuals to appropriate medical, mental health and substance abuse services, which in turn has the potential to reduce recidivism. In 2018, the enrollment process is now active at all 28 state prisons and approximately 25,000 individuals have been enrolled in Medicaid with an ability to immediately access services upon release.

Comprehensive Primary Care Support. In January of 2018, ODM launched a quality improvement project with MCPs and CPCs designed to improve managed care plan support of comprehensive primary care practices in order to increase the percentage of high risk patients receiving preventive care. Although the project is still in its infancy, primary strategies by the MCPs implemented to date have included building trusting relationships with the CPCs, assessing the accuracy of claims data used to determine patient attribution to a CPC practice, and outreach to patients to determine barriers to utilizing primary care.

Infant Mortality Reduction Initiatives

Progesterone Initiation Performance Improvement Project (Progesterone PIP). The Progesterone PIP which began in January of 2015 is currently being sustained and spread. During the implementation period of the PIP the following interventions were found to be effective: maintenance of Medicaid eligibility through notifying the county departments of job and family services (CDJFS) of pregnancy; providing a simplified and standardized communication tool for this notification and for communicating patient needs, including progesterone, to managed care plans and their contracted home health agencies and specialty pharmacies of patient needs; and assigning dedicated MCP staff as progesterone navigators to assist when issues arise around obtaining progesterone.

The standardized pregnancy risk assessment form (PRAF) that was developed in order to streamline communication among partners (CDJFS, MCPs, MCP contracted home health agencies and specialty pharmacies) has been converted to a web-based format (PRAF 2.0) that allows daily communication between systems. In the summer of 2018, pregnancy notifications from the PRAF 2.0 will be integrated directly into Ohio's Medicaid eligibility system (Ohio Benefits) on a daily basis and will interface with the Ohio Department of Health's Ohio Comprehensive Home Visiting Integrated Data System (OHCIDS). These integrations will further reduce the risk of Medicaid coverage loss during pregnancy and will allow for increased efficiencies in communicating educational and follow-up needs with Ohio's Home Visiting program.

Home Visiting Referrals. ODM is actively working with its five contracted Medicaid Managed Care Plans, the Ohio Department of Health, and key stakeholders to capitalize on the strengths of home visiting programs and remove duplicative efforts. This effort involves increasing referrals to home visiting programs through integration of data from the web-based Pregnancy Risk Assessment Form (PRAF 2.0) with the Ohio Department of Health's OCIDS. Home visitors will be assisting those referred in navigating the health system, including accessing progesterone and connecting with programs to address substance and tobacco use. Discussions are currently underway to reduce duplication and increase synergy between Managed Care and Home Visiting by feeding back the results of assessments and educational activities to Ohio Medicaid Managed Care Plan.

Smoke Free Families Perinatal Improvement Project. In partnership with the Ohio Department of Health (ODH) and the Ohio Department of Medicaid (ODM), the Ohio Smoke Free Families Perinatal Learning Collaborative focuses on reducing the use of tobacco among Medicaid women during pregnancy in order to improve birth outcomes. The Smoke Free Families-Perinatal project will build on the accomplishments of previous tobacco cessation initiatives and expand resources and interventions for pregnant women. Through the project, Cincinnati Children's Hospital Medical Center – Ohio Perinatal Quality Council will seek to recruit high volume OB-GYN sites for participation in a quality improvement learning collaborative alongside ODH funded program sites and Federally Qualified Health Centers (FQHCs). Participating sites will receive training on the Ohio Smoke Free Families provider toolkit, "5 A's" (Ask, Advise, Assess, Assist, and Arrange), "5 R's" (Relevance, Risks, Rewards, Roadblocks, and Repetition) and motivational interviewing, as well as implementing tools and interventions at their site.

Smoke Free Families Pediatric Improvement Project. The Smoke Free Families-Pediatric project aims to reduce the use of tobacco among women postpartum and the exposure to secondhand smoke of their infants and other family members, by screening mothers and other caregivers when they visit their primary care provider and assisting them in quitting through implementation of the "5 A's" plan to quit smoking.

Participating sites will also receive training on the Ohio Smoke Free Families provider toolkit, the "5 A's", the "5 R's", motivational interviewing and one-on-one counseling, as well as effectively implementing these tools and interventions at their sites. The goal is to achieve at least 25% reduction in the number of children exposed to second hand smoke.

Efforts in Ohio's Equity Institute Communities. Through Ohio's Managed Care Plans, ODM funded community-led efforts to promote better birth outcomes within nine Ohio communities with disproportionately high levels of infant mortality. In CY 2015 and early 2016, each community, ODM and its contracted MCPs held town hall meetings to gain a more in-depth perspective of the challenges faced, the needs perceived, and existing community initiatives for addressing them. As a result of these meetings, ODM called for proposals to address the gaps identified.

In 2016, ODM invested \$26.8 million to support 46 community-driven projects in nine metropolitan areas that accounted for 59 percent of all infant deaths, and 86 percent of African American infant deaths. ODM is dedicating an additional \$26.8 million throughout 2018–2019, to support community-driven interventions with proven track records to help reduce infant mortality locally. These

interventions are focused on outreach and connection for our highest risk moms. Current programs are focused on the use of community health workers (CHW), home visiting (HV) and Centering Pregnancy models.

ODM has contracted with the Government Resource Center (GRC) to conduct an evaluation of these activities. In addition, ODM has contracted with Health Services Advisory group to complete periodic reviews to determine barriers faced by Medicaid recipients in gaining full access to interventions intended to reduce tobacco use, prevent prematurity, and promote optimal birth spacing.

The initial assessment of the barriers identified through interviews with key informants representing seven Ohio CBOs and five focus groups with Medicaid-enrolled women between the ages of 15 and 44 will be completed in SFY 2018. This information will assist Medicaid in determining how to further infant mortality reduction policy and programs.

Initiatives Targeting Opioid Use Disorder

Neonatal Abstinence Syndrome (NAS) Improvement Project. The Neonatal Abstinence Syndrome (NAS) project is another statewide improvement initiative that addressed the population streams of Behavioral Health and Women of Reproductive Age (now Women's Health). Over the course of the project, interventions focused on compassionate care, community outreach, and high calorie formula, resulted in a two day reduction in the NICU length of stay for pharmacologically treated babies. This partnership with the Ohio Perinatal Quality Collaborative (OPQC), is currently focused on sustaining efforts, refining treatment protocols, and continuing to offer support to participating sites.

Maternal Opiate Medical Supports (MOMS) Improvement Project. Funded jointly by the Governor's Office of Health Transformation, ODM, and the Ohio Department of Mental Health and Addiction Services (OMHAS), the Maternal Opiate Medical Supports (MOMS) quality improvement initiative addressed two population streams: maternal and child health and behavioral health. Through the use of Medication Assisted Therapy (MAT), the MOMS project increased use of prenatal care, behavioral health care, and MAT in each trimester of pregnancy. MOMS participants were also 45% more likely to continue to participate in substance abuse treatment four to six months postpartum and infants born to mothers who received MAT in the third trimester of pregnancy had significantly shorter NICU stays.

Maternal Opiate Medical Supports Plus (MOMS+) Improvement Project. Key learnings from the MOMS and NAS projects have helped shape the next phase of the project, Maternal Opiate Medical Supports Plus (MOMS+). Using an obstetrical specialty model MOMS+ offers MAT induction by a specialized Obstetrician who assists in helping local obstetricians maintain MAT and provide access to needed psychological services. The program operates based on a "hub and spoke" framework with obstetrical specialists ("hubs") receiving referrals from local obstetricians ("spokes") who in turn benefit from the sharing of expertise and coordinated care for their patients. MAT/Opioid Treatment Program, Behavioral Health and Neonatal services to compassionately coordinate clinical and community-based services in order to support the mother-infant dyad post-delivery. MOMS+ will implement strategies to increase MAT access during all trimesters of pregnancy and improve treatment retention during the third trimester and postpartum, incorporate pediatrics into the maternal care home model, promote tobacco cessation for better infant outcomes, collaborate with child protective services to reduce out-of-home placement, provide additional parenting skills education and early home intervention series,

and collaborate with MCPs to support treatment integration and retention. Goals of the project include: increasing the percentage of women with opioid use disorder during pregnancy who receive prenatal care, MAT, and behavioral health counseling each month; decreasing the percentage of full-term infants with neonatal abstinence syndrome requiring pharmacological treatment; and increasing the percentage of babies who go home with mother after delivery.

Chronic Condition Interventions

Hypertension Control Improvement Project. In 2017, ODM received permission to align MCPs and MCOPs in the use of quality improvement science based approaches to impact health outcomes. ODM launched the hypertension improvement project In January 2018. This project became the federally required performance improvement project for the Medicaid Managed Care Plans and the new Quality Improvement project for the MyCare Ohio plans.

The effort differs significantly from the MyCare Chronic Condition Improvement Project in that it has an equity focus, utilizes frequent data collection via clinical electronic health records, requires collaboration with participating practices, capitalizes on electronic health record data, and uses quality improvement science tools and methods to more rapidly determine needed adaptations in order to spread successful interventions.

The Hypertension Improvement Project is aimed at the Medicaid population of adults with chronic conditions, specifically cardiovascular disease as exhibited by uncontrolled hypertension. This project includes a focus on health disparities, informed by data demonstrating much higher rates of uncontrolled hypertension among African American compared Caucasian patients. To begin closing this disparity, the project SMART aims include improving the control of hypertension by 15% in the overall study population and 20% in the African American population. The effort involves spreading clinical best practices shown to be effective in controlling hypertension and reducing disparities. The project's key drivers and interventions include: accurate blood pressure measurement, timely follow-up for high blood pressure, tailoring of outreach and communication to be culturally appropriate and adherence to a medication treatment algorithm. Partner practice sites were selected in part for strong representation of African American patients (approximately 40% of the total study patient population).

Gestational Diabetes Mellitus (GDM). The Ohio Department of Health and Ohio Medicaid are partnering to increase the number of women with a history of Gestational Diabetes Mellitus (GDM) who receive recommended screening and education for type 2 diabetes (T2DM).

Participating practices test interventions, including the piloting of clinical and patient toolkits that include the following resources: clinical decision algorithms for diagnosing GDM and T2DM; office flow charts for assessing GDM and screening for T2DM; and recommendations for improving care coordination between prenatal and primary care providers.

The 29 original Ohio OB-GYN and Maternal Fetal Medicine practices are now focused on sustaining successful processes developed as part of quality improvement interventions to improve rates for: timely screening of pregnant women for gestational diabetes; postpartum visits; and postpartum T2DM screening within recommended timeframes.

Currently, 15 Ohio Primary Care Practices are engaged in testing interventions to improve rates for: assessing women for a history of GDM or at risk for T2DM; and improving T2DM screening rates throughout the life course.

The next wave of the project will involve testing the provision of postpartum care and GDM screening in a dyad care model, allowing both mom and child to be assessed and provided with care by a family practitioner. Planning is also underway to test using the home visiting model to assist women in getting to their postpartum visit.

Promoting Effective Behavioral Health Care

Pharmacogenomics testing (PGx). The Pharmacogenomics project is a collaborative partnership between the Ohio Department of Medicaid, the Government Resource Center (GRC), the Ohio State Wexner Medical Center, and Northeast Ohio Medical University focused on assessing the potential benefit of pharmacogenomics testing to Medicaid enrollees impacted by genotype testing and the potential cost-effectiveness to the Medicaid program of covering genetic testing for specific high frequency psychotropic medications. The project is currently in the development phase.

Patient, Family and Community Centered Approaches

Social Determinants of Health. Much of what impacts the health of individuals is outside the purview of the medical setting. Social determinants of health, such as a safe living environment and neighborhood, stable housing, the availability of transportation, adequate and healthful food, and quality childcare all have an impact on the ability of Medicaid recipients to be actively engaged in their own health and wellbeing and to take ownership of their healthcare.

Managed care plans, through their active role in assessment of needs and care coordination, ability to link to multiple community supports, and unique availability to track healthcare utilization over time, have a unique role in addressing social determinants of health. In SFYs 2016 and 2017, ODM continued strengthening collaborative relationships with the MCPs, other state agencies, advocacy groups, the provider community, and nonprofits in projects and initiatives that addressed the role of social determinants as they impact population health. This includes approaches that focus on prevention to produce better health outcomes and health cost savings.

In July of 2017, ODM required each MCP to devote at least one full time position to community engagement activities. These positions are intended to bolster MCP-community relations, increase MCP understanding of community needs, and increase community trust of MCPs with the desired outcome being increased ability to address social determinants of health.

Responsibilities of the community engagement positions include: serving as the MCP's primary points of contact for ODM-sanctioned improvement efforts involving community-based organizations and requiring community outreach and involvement in priority communities (e.g., community-based infant mortality reduction); attending or overseeing MCP attendance at community events in priority communities (e.g., trainings, racism dialogues, infant mortality awareness events); in-person communication with funded community-based organizations in order to bolster the presence of the MCP itself as a collaborative and trusted partner of the CBO and as a supporter of the ODM initiative; collaborating with other MCPs' coordinators to communicate and address community concerns;

coordinating the tracking and submission of process measures, as needed, related to MCP improvement efforts in communities (e.g. infant mortality reduction efforts in high priority areas); identifying additional community engagement opportunities and developing a plan to participate in or support those opportunities; and responding to ODM inquiries related to MCP community engagement activities.

Incentivizing MCP Performance

Historically, ODM has had a pay-for-performance (P4P) incentive system to encourage improvement in the quality of care delivered to MMC plan enrollees. The P4P incentive system emphasized performance measures that supported the quality strategy priorities and goals.

The incentive system was established in SFY 2002 for the Covered Families and Children (CFC) Medicaid population and was extended to the Aged, Blind, and Disabled (ABD) Medicaid population in SFY 2009 and is continually updated to reflect ODM Managed Care priorities. Stakeholders were given the opportunity to comment on the selection of measures and thresholds chosen for the P4P incentive system during the MMCP and MCOP provider agreement comment periods.

For SFY 2018, two P4P incentive system determinations will be made per MMCP; one determination will evaluate MMCP clinical quality, while the other will evaluate MMCP care management readiness and performance. Results for each P4P measure or requirement will be calculated per MMCP, statewide, and include all regions in which the MMCP has membership. For the Clinical Performance P4P determination, MCPs will be required to develop and implement improvement initiatives in areas of low performance.

The P4P Incentive System clinical measures are aligned with the Quality Strategy and reflect clinical focus areas of priority to Ohio Medicaid. MCPs are expected to maintain a focus on continuous quality improvement in these areas. To monitor MMCP quality improvement using this system, ODM required MCPs to develop and implement quality improvement projects when yearly-specified standards were not met. Yearly standards are contained in the MMC Provider agreement which is available on the Medicaid website (Medicaid.ohio.gov).

Beginning in CY 2018, ODM will transition from an incentive based system to a quality withhold system. This new structure will withhold 2.0% of the calendar year capitation and delivery payments for each Medicaid Managed Care Plan (MCP) for use in the Quality Withhold (QW) Program. For CY 2018, the 2.0% withhold will apply to capitation and delivery payments from April through December 2018. In subsequent years, the amount withheld will apply to the entire calendar year's capitation and delivery payments.

ODM will use Quality Indices to measure the effectiveness of the MCP's population health management strategy and quality improvement program in impacting population health outcomes. Quality indices will be comprised of multiple performance measures related to the index topic and a separate score will be calculated for each Quality Index. Index scores will be used to determine the MCP's annual Quality Withhold Payout. Payouts will be index-specific. Potential Payout per Index equals Total Withhold Amount divided by four.

The Quality Indices used in the QW program for SFY 2019 (measurement year CY 2018) are:

1. Chronic Condition: Cardiovascular Disease;
2. Chronic Condition: Diabetes;
3. Behavioral Health; and
4. Healthy Children.

Women’s Health measures will be used to influence Quality Based Assignment so that plans with higher performance on these measures have a greater percentage of new Medicaid enrollees assigned to them.

A comparison of the measures contained within the Quality Withhold and P4P models is below. The measures used in the Quality Based Assignment and Quality Withhold Incentive Systems each year are denoted with a QBA or QW. These measures, as well as those with no standard or compliance assessed (reporting only) measures are also included in Appendices A and B.

Figure 8. Comparison of P4P and Quality Withhold Measures

Quality Indices & Measures	State Fiscal Year	P4P	Quality Withhold / Quality Based Assignments
	Measurement Year	SFY 2018 CY 2017	SFY 2019 CY 2018
Behavioral Health			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation			QW
Follow-up After Hospitalization for Mental Illness, 7-Day Visit		P4P	QW
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			QW Beginning CY 2020
Use of Multiple Concurrent Antipsychotics in Children and Adolescents			QW
Chronic Condition: Cardiovascular Disease			
Controlling High Blood Pressure		P4P	QW
Statin Therapy for Patients with Cardiovascular Disease – Received Statin Therapy			QW
Adult BMI			QW Beginning CY 2019
Chronic Condition: Diabetes			
Hemoglobin A1c (HbA1c) testing			QW
HbA1c poor control (>9.0%)		P4P	QW
Eye exam (retinal) performed			QW
BP control (<140/90 mm Hg)			QW
Healthy Children			
Well-Child Visits in the First 15 Months of Life			QW
Well-Child Visits in the 3 rd , 4 th , 5 th , 6 th Years of Life			QW
Adolescent Well-Care Visits		P4P	QW
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI percentile documentation			QW Beginning CY 2019
Women’s Health			

Percent of Live Births Weighing less Than 2,500 grams		QBA
Timeliness of Prenatal Care	P4P	QBA
Postpartum Care	P4P	QBA
Breast Cancer Screening		QBA
Cervical Cancer Screening		QBA

As illustrated above, data is essential to assessing the performance of ODM’s quality system. In support of this work, ODM has established requirements around contracted-MCP health systems and continually strives to improve its own eligibility and claims systems, as well as internal analytical capacity. These efforts are key to the creation and maintenance of an integrated health system.

Health Information Systems

ODM requires MCPs and MCOPs to maintain health information systems that collect, analyze, integrate, and report data. These systems must provide information on areas including, but not limited to, utilization, grievances and appeals, and MCP membership terminations for issues other than loss of Medicaid eligibility. The MCP must collect data on member and provider characteristics and also on services furnished to its members. In addition, the MCP or MCOP must ensure that data received from the providers is accurate and complete by verifying the accuracy and timeliness of reported data, and consistency, and collecting services information in standardized formats to the extent feasible and appropriate. Finally, MCPs/MCOPs are required to make all data available to ODM and/or CMS upon request. ODM has data quality measures in place to ensure MCP submissions are up to standard.

In 2011, ODM transformed its technological infrastructure through the development of a Medicaid information technology architecture (MITA)-compliant system called the Medicaid Information Technology System (MITS). MITS replaced the Medicaid Management Information System (MMIS), an outdated legacy data management and claims processing system, and Athena, a managed care program data system to support quality of care data collection and analysis. ODM received federal matching funds for much of the system’s design, development, and implementation.

ODM is currently developing requests for proposals to replace the MITS system with a modular system that will allow more agility as the program continues to transform.

Updated eligibility system

The Governor’s Office of Health Transformation initiated an eligibility modernization project to simplify client eligibility based on income, streamline state and local responsibility for eligibility determination, and modernize eligibility systems technology. The new system, Ohio Benefits, successfully launched in October 2013 and, over the next two years, completely replaced Ohio’s 32-year-old Client Registry

Information System Enhanced (CRIS-E). One of the benefit for individuals is that they can learn of their eligibility for Medicaid and any other income-tested program based on income tax information without needing to undergo any additional eligibility tests.

Electronic Visit Verification (EVV)

MCPs will be required to implement the ODM established EVV system no later than May 6, 2019 for the following services: Private Duty Nursing; State Plan Home Health Aide; State Plan Home Health Nursing; RN Assessment. Additionally, MCOPs are required to implement EVV for the following services: Waiver Nursing, Waiver Personal Care Aide, and Waiver Home Care Attendant. The MCPs will use data collected from the EVV data collection system data to validate all claims during the claim adjudication process. Prior to implementation, the MCPs are required to inform providers of the use of the EVV data collection system and how the data will be utilized by the MCP. The MCPs are also required to provide assistance on utilization of the data collection system, as appropriate, to individuals receiving services, direct care workers and providers.

Integration of the Ohio Automated Rx Reporting System and EHRs

The Ohio Automated Rx Reporting System (OARRS) monitors the dispensing of controlled prescription for suspected abuse or diversion (i.e., channeling drugs into illegal use). Prescribers and pharmacists can use this system to obtain critical information regarding a patient's controlled substance prescription history. The Ohio Department of Medicaid (ODM) is working with The State of Ohio Board of Pharmacy (BOP) to integrate with Electronic Health Record systems. Having OARRS information integrated directly into a provider's EHR will make it easier for providers to meet the meaningful use requirements for medication reconciliation and identify high-risk patients who would benefit from early interventions.

Updated Analytical Capacity

Server-based Statistical Analysis Software (SAS) is a centralized metadata server for storing, managing, and delivering metadata for SAS applications. This software provides ODM centralized access to consistent, timely, and accurate data, which allows for enhanced analysis to support population health management.

Geographic Information Systems (GIS) are utilized to evaluate access to services by examining the geographic relationships between MMCP providers and managed care enrolled individuals. GIS software is used to determine areas where improvement efforts can have the most impact and where access to care may need the most improvement. A dashboard system has been developed to show how key outcomes are changing across time and geography. This information is used to evaluate the quality strategy and to inform the focus of ODM's improvement efforts.

Ohio Medicaid's Quality Decision Support System (QDSS) is a business intelligence application that supports data driven decision-making within ODM by allowing for the analysis of claims, encounter and eligibility data.

Sustaining a Quality-Focused, Data-Informed, Continuous Learning Organization

The transparent exchange of data is essential to building an efficient and effective health care system. ODM uses data to assess and reward provider and MCP performance. Some examples of data shared across the system are outlined below.

CPC reports

Ohio's CPC Program financially rewards primary care practices that keep people well and hold down the total cost of care. The CPC program includes quality metrics that drive improvement in maternal and infant health, mental health and addiction, and chronic disease. The CPC Program has eight activity requirements, four efficiency measures, and 20 clinical measures.

CPC's must pass 100% of the eight activity requirements:

- *Same-day appointments,*
- *24/7 access to care,*
- *Risk stratification,*
- *Population management,*
- *Team-based care management,*
- *Follow up after hospital discharge,*
- *Tracking of follow up tests and specialist referrals, and*
- *Patient experience*

Fifty percent of the four efficiency measures need to be met

- *ED visits*
- *Inpatient admissions for ambulatory sensitive conditions*
- *Generic dispensing rate of select classes*
- *Behavioral health related inpatient admits*

There are also 20 clinical measures that are aligned with core standards for PCMH models. CPC practices must pass 50% of these measures.

The CPC referral reports are published quarterly, allowing Ohio's CPCs, MCPs and ODM to more rapidly determine progress. A sample CPC Quarterly Progress Report can be found at medicaid.ohio.gov.

Episodes of Care

In parallel to the CPC model, Ohio's Episodes of Care model reimburses providers based on performance and quality metrics. Incentive payments are calculated based on the outcomes of the previous 12 month performance period. Claims are reviewed to determine the principle accountable provider (PAP) who will either receive the reimbursement payment if costs are below commendable levels and quality targets are met or be responsible for a negative incentive if average costs are above the acceptable level. If average costs are between commendable and acceptable levels, the PAP would see no cost impact.

Episode of Care Performance Reports are available on the Ohio Medicaid MITS portal and help providers, MCPs and ODM see performance at a glance. A sample Episode of Care Provider Report can be found at medicaid.ohio.gov.

Linkage between vital statistics and ODM claims and eligibility data

To maintain a quality focused and data-informed emphasis, ODM has created a process to improve the linkage between vital statistics and ODM claims and Eligibility data. This linkage will help ODM have access to information that assist with quality measurement for priority populations.

Increased communication between practitioners and MCPs

Overcoming barriers to effective communication is key to improvement efforts. To address this, the Progesterone PIP instituted a standardized Pregnancy Risk Assessment Form (PRAF) for notifying MCPs of pregnancy so that psychosocial needs, progesterone needs and eligibility issues could be addressed more efficiently. The content of the PRAF went through iterative testing including testing the use of an online application for data entry and distribution of information to appropriate entities, such as MCPs, MMCP contracted Home Health Agencies, and CDJFS eligibility offices. Plans are currently underway to integrate the information with Ohio's Eligibility system, Ohio Benefits, and Ohio's Home Visiting database to further reduce inefficiencies in provision of insurance coverage and health services.

Hospital Performance

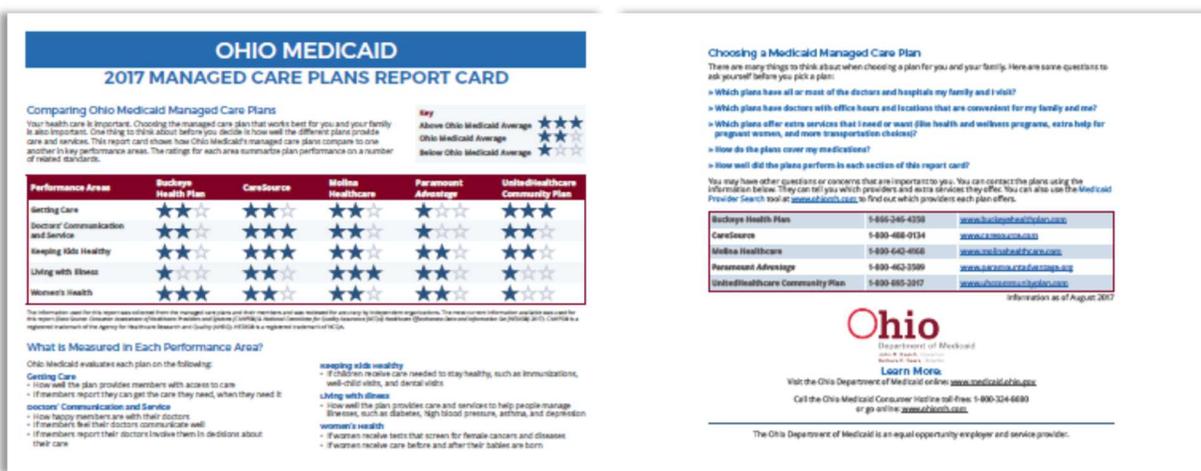
Transparency in hospital performance presents an opportunity to make care safer by helping to monitor and prevent avoidable readmissions. In a further effort to prevent hospital readmissions, the Ohio Department of Medicaid (ODM) implemented a healthcare quality initiative to reduce preventable readmissions for hospital stays and introduced a hospital report card which displays four years' worth of preventable hospital readmissions that occurred within 30-days of the initial hospital stay

In the future, rewards or penalties may be imposed based upon a hospital's performance over time. This approach is similar to one that the Medicare program has implemented. Unlike Medicare, however, ODM's Potentially Preventable Readmission (PPR) program uses more types of hospital stays and factors in the clinically related aspect of the stays. Coordinated discharge planning between hospitals and MCPs is essential in helping to reduce the PPR.

Managed Care Report Cards

In 2015, ODM published its first consumer-facing Medicaid managed care report card on the [ODM](#) website. The report card compares Ohio's MMC plans across five performance areas which align with Ohio's goals and population streams: (1.) getting care; (2.) doctors' communication and service; (3.) keeping children healthy; (4.) living with illness; and (5.) women's health. Each plan is assigned up to three stars to indicate how it performs relative to other plans on each of these five measures. The information used to create the Medicaid managed care report is collected from the MMCs and their members and is reviewed for accuracy by independent organizations. The most current information from the National Committee for Quality Assurance [NCQA] Healthcare Effectiveness Data and Information Set (HEDIS®) & the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is used. Below is the report card for 2017.

Figure 9. 2017 Medicaid Managed Care Report Card



Geographic Performance Data visualization

ODM is developing graphical dashboards for infant mortality and behavioral health which allow MCPs, CDJFS, Ohio Equity Institute Communities, and state partners to view longitudinal depictions of MMCP performance measures by geographical location. This increased transparency will highlight areas with poor outcomes, helping to target improvement efforts and allowing improvement to be easily gauged over time. The dashboards will be shared with local health departments, MCPs, and other partners to help target coordinated improvement efforts.

VI. Conclusions and Opportunities

Successes, Partnerships, and Best Practices

ODM has a number of future initiatives that encourage the application of continuous quality improvement. These include training in quality improvement science methods, a revamping of improvement projects to include a focus on rapid cycle improvement, and leveraging of payment structure and existing partnerships.

Quality Improvement Science Training and Improvement Redesign

Using Adult Medicaid Quality Grant Funding, ODM and its MCPs have gained training and practical experience in the application of rapid cycle quality improvement science methods. The knowledge gained through leadership training provided by the James M. Anderson Center for Health Systems Excellence at the University of Cincinnati Children's Hospital enabled ODM to redesign its performance improvement projects to incorporate rapid cycle testing and statistical process control, leading to more rapid and sustainable improvement and aligning with other quality improvement initiatives within the state of Ohio. The Managed Care Improvement Science (MCIS) Project and simultaneous MCP QI Executive Leadership Training sponsored by ODM and facilitated by the Anderson Center that commenced late in 2017 are examples of ODM's commitment to enhance QI science expertise across the managed care plans.

Medicaid Technical Assistance and Policy Program (MEDTAPP)

MEDTAPP is a research partnership between Ohio universities and Medicaid that combines nonfederal and federal funds to support the efficient and effective administration of the Medicaid program. MEDTAPP partners include the Ohio Department of Medicaid, the Ohio Department of Health, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Development Disabilities, the Ohio Board of Regents, and the Ohio Colleges of Medicine Government Resource Center. MEDTAPP's focus areas have included 1) workforce development; 2) quality improvement initiatives, and 3) rapid technical and clinical consultation.

MEDTAPP has contributed to the overall service quality by providing funding and coordination for improvement projects. Examples of these were described in previous sections. In the future, ODM will be moving the focus of MEDTAPP towards building provider and MMCP relationships, communication and collaboration so that quality improvement efforts are more readily coordinated.

Challenges in Improving Quality of Care

Over the past few years, ODM has been faced with a number of challenges to improving quality of care. These have included an outdated Performance Improvement Project structure that focused more heavily upon documentation than achieving results, uncoordinated care, a lack of transparency and communication between Ohio's providers and managed care entities, and a minimalistic approach to care coordination by Ohio's MCPs.

These challenges are being addressed through several activities, including: the redesign of Ohio's Medicaid improvement projects to incorporate data driven approaches and rapid cycle methods of quality improvement through alignment with the Model for Improvement used by the Institute for Healthcare Improvement; efforts to eliminate fragmentation in the care delivery system (MyCare Ohio, Behavioral Health Redesign, etc.), promoting value based payment strategies such as episodes of care and the CPC model of care, increasing transparency through the use of provider and managed care report cards and dashboards showing performance on key metrics, increasing the collaborative use of data (geographical displays using Tableau), and the expansion of tailored care coordination to 100 percent of managed care enrollees.

Opportunities Involving Data

Ohio has implemented a number of initiatives that capitalize on current data collection systems in new and innovative ways. These include: the creation and publishing of a Medicaid managed care report card to assist future enrollees in choosing a plan; MMC use of monthly redetermination files to help pregnant women maintain Medicaid coverage; MMC use of linked vital statistics-Medicaid claims files for early identification of women who may be at risk for a poor pregnancy outcomes but are not yet pregnant; and increased communication between providers and MMCs to streamline the identification of pregnant women that would benefit from MMC assistance with psychosocial needs, eligibility processes, and removal of barriers to progesterone initiation.

Ongoing Medicaid Quality Improvement Activities

Future Medicaid quality improvement activities will address improving services and health outcomes within population streams: (1.) women's health; (2.) behavioral health of adults and children; (3.) chronic conditions among adults and children and; (4.) healthy children and adults. Structuring improvement projects in this way allows for more effective alignment and coordination with other initiatives and more efficient stakeholder involvement.

Over the next few years, ODM will be working more closely with the MCOPs to align the QIP and CCIP with quality improvement science methods to encourage more rapid cycle change. This alignment is part of a larger effort to build a culture of improvement across Ohio Medicaid's delivery system. As part of this effort, ODM is investing in building quality improvement leadership and staff capacity in each contracted managed care plan, while also standardizing its approach to quality improvement. This includes focusing on measurement and ongoing evaluation to more quickly and accurately determine intervention and programmatic effectiveness. ODM has dedicated program staff in quality and performance improvement to assist the MCPs in optimizing the impact of improvement initiatives and in evaluating the effectiveness of their programs.

ODM performance and improvement staff actively work with Ohio's contracted MCP's in order to understand their approaches to quality, identify additional areas for improvement, and spread best practices.

Next Steps

Ohio Medicaid will continue looking for innovative ways of improving the health of Ohioans through service delivery in a Managed Care environment. ODM is committed to promoting a system dedicated to quality over volume and will continue to foster approaches that improve the health and economic vitality of Ohioans in an efficient and cost-effective manner. Person-centered care that empowers individuals in making their own healthcare decisions and honors personal choice will continue to be a priority. Increased methods for assuring data sharing and transparency will help us achieving desired outcomes through promoting greater coordination of care, responsiveness, integrity and accountability.

ODM's guiding principles have assisted in the expansion of Managed Care to additional populations, traditionally covered through the FFS delivery system. Populations which have been recently enrolled in Managed Care include children receiving services from the Ohio Department of Health's Bureau of Children with Medical Handicaps, adopted children and children in foster care, individuals enrolled on waivers administered through the Department of Developmental Disability, and women receiving services through the Breast and Cervical Cancer Program. In July, 2018, behavioral health treatment

services, historically provided on a fee for service basis, will be integrated into managed care, providing opportunities to enhance coordination of primary and behavioral healthcare.

ODM will continue to actively support its' contracted MCPs in the pursuit of quality by fostering opportunities for learning and collaboration, providing coaching resources for quality improvement activities, and providing a clear vision for improving the care of Ohioans.

APPENDIX A—MMC QUALITY MEASURES AND STANDARDS

APPENDIX A—MMC QUALITY MEASURES AND STANDARDS

MMC FY 2017, SFY 2018 and SFY 2019 Performance Measures, Measurements Sets, Standards, and Measurement Years.

Measure	Measurement Set	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
Quality Strategy Population Stream: Healthy Children							
Well-Child Visits in the First 15 Months of Life – Six or More Well-Child Visits	NCQA/HEDIS	≥ 51.8%	CY 2016	≥ 53.5%	CY 2017	QW	CY 2018
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA/HEDIS	≥ 65.5%	CY 2016	≥ 64.7%	CY 2017	QW	CY 2018
Adolescent Well-Care Visits	NCQA/HEDIS	≥ 41.8%*	CY 2016	≥ 40.9%*	CY 2017	QW	CY 2018
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	≥ 40.24%	CY 2018
Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months, 25 Months - 6 Years, 7-11 Years, and 12-19 Years	NCQA/HEDIS	12-24 mos. ≥ 94.2%	CY 2016	12-24 Mos. ≥ 93.1%	CY 2017	12-24 Mos. ≥ 93.27%	CY 2018
		25 Mos. - 6 Yrs. ≥ 85.4%		25 Mos. - 6 Yrs. ≥ 84.8%		25 Mos. - 6 Yrs. ≥ 84.94%	
		7-11 Yrs. ≥ 88.9%		7-11 Yrs. ≥ 87.9%		7-11 Yrs. ≥ 87.58%	
		12-19 Yrs. ≥ 87.3%		12-19 Yrs. ≥ 85.8%		12-19 Yrs. ≥ 85.65%	
Appropriate Treatment for Children With Upper Respiratory Infection	NCQA/HEDIS	≥ 84.2%*	CY 2016	Eliminated Effective SFY 2018			

APPENDIX A—MMC QUALITY MEASURES AND STANDARDS

Measure	Measurement Set	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
Appropriate Testing for Children With Pharyngitis	NCQA/HEDIS	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Reporting Only**	CY 2018
General Child Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS/CAHPS	≥2.51	CY 2016 (Survey conducted in CY 2017)	≥ 2.51	CY 2017 (Survey conducted in CY 2018)	≥ 2.51	CY 2018 (Survey conducted in CY 2019)
General Child - Customer Service Composite (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	Not Applicable	Not Applicable	≥ 2.50	CY 2017 (Survey conducted in CY 2018)	≥ 2.50	CY 2018 (Survey conducted in CY 2019)
Annual Dental Visits, Total Rate	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Childhood Immunization Status (Combo 2)	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Childhood Immunization Status (Combo 3)	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Childhood Immunization Status (Combo 10)	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Immunizations for Adolescents (Combo 1)	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition, Counseling for Physical Activity	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Quality Strategy Population Stream: Women of Reproductive Age							
Frequency of Ongoing Prenatal Care – ≥ 81	NCQA/HEDIS	≥ 46.7%	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminate d Effective SFY 2018

APPENDIX A—MMC QUALITY MEASURES AND STANDARDS

Measure	Measurement Set	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
Percent of Expected Visits							
Prenatal and Postpartum Care - Timeliness of Prenatal Care	NCQA/HEDIS	≥ 77.4%*	CY 2016	≥ 74.2%*	CY 2017	QBA ≥ 64.48	CY 2018
Prenatal and Postpartum Care - Postpartum Care	NCQA/HEDIS	≥ 55.5%*	CY 2016	≥ 55.5%*	CY 2017	QBA ≥ 45.76	CY 2018
Percent of Live Births Weighing Less Than 2,500 Grams	CHIPRA	≤ 10.3%	CY 2016	≤ 10.3%	CY 2017	QBA ≤ TBD	CY 2018
Human Papillomavirus Vaccine for Female Adolescents	NCQA/HEDIS	Not Applicable	CY 2016	Not Applicable	CY 2017	Not Applicable	CY 2018
Immunization for Adolescents (HPV)	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Chlamydia Screening in Women, Total	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Quality Strategy Population Stream: Behavioral Health							
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation of AOD Treatment Total, Engagement of AOD Treatment Total	NCQA/HEDIS	Not Applicable	Not Applicable	Reporting Only	CY 2017	Initiation Total	CY 2018
						QW	
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	7-Day Follow-up ≥ 32.0%*	CY 2016	7-Day Follow-up ≥ 34.2%*	CY 2017	7-Day Follow-up	CY 2018
		30-Day Follow-up Not Applicable		30-Day Follow-up Reporting Only		30-Day Follow-up	

APPENDIX A—MMC QUALITY MEASURES AND STANDARDS

Measure	Measurement Set	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
						Reporting Only **	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total	NCQA/HEDIS	≥ 60.2%	CY 2016	≥ 48.8%	CY 2017	≥ 53.81%	CY 2018
Use of Multiple Concurrent Antipsychotics in Children and Adolescents, Total	NCQA/HEDIS	Reporting Only	CY 2016	≤ 3.1%	CY 2017	QW	CY 2018
Metabolic Monitoring for Children and Adolescents on Antipsychotics, Total	NCQA/HEDIS	Reporting Only	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018
Antidepressant Medication Management – Effective Acute Phase Treatment, Effective Continuation Phase Treatment	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Acute Phase ≥ 42.17%	CY 2018
						Continuation Phase Reporting Only**	
Follow-Up Care for Children Prescribed ADHD Medication	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Mental Health Utilization	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Follow-Up After Emergency Department Visit for Mental Illness	NCQA/HEDIS	Not Applicable	CY 2016	Not Applicable	CY 2017	7-Day Follow-up Reporting Only	CY 2018
						30-Day Follow-up Reporting Only	
	NCQA/HEDIS		CY 2016		CY 2017		CY 2018

APPENDIX A—MMC QUALITY MEASURES AND STANDARDS

Measure	Measurement Set	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence, Total		Not Applicable		Not Applicable		7-Day Follow-up Reporting Only	
						30-Day Follow-up Reporting Only	
Use of Opioids at High Dosage	NCQA/HEDIS	Not Applicable	CY 2016	Not Applicable	CY 2017	Reporting Only	CY 2018
Use of Opioids From Multiple Providers- Multiple Providers, Multiple Pharmacies, Multiple Prescribers and Multiple Pharmacies	NCQA/HEDIS	Not Applicable	CY 2016	Not Applicable	CY 2017	Reporting Only	CY 2018
Quality Strategy Population Stream: Chronic Conditions							
Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)	NCQA/HEDIS	Not Applicable	Not Applicable	≤ 52.3%	CY 2017	QW	CY 2018
Comprehensive Diabetes Care – HbA1c Testing	NCQA/HEDIS	Not Applicable	Not Applicable	Reporting Only	CY 2017	QW	CY 2018
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	NCQA/HEDIS	≥ 47.1%	CY 2016	≥ 44.5%	CY 2017	QW	CY 2018
Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	NCQA/HEDIS	≥56.5%	CY 2016	≥ 52.3%	CY 2017	QW	CY 2018
Comprehensive Diabetes Care – HbA1c Control (<8.0%)	NCQA/HEDIS	≥40.0%*	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018

APPENDIX A—MMC QUALITY MEASURES AND STANDARDS

Measure	Measurement Set	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
Statin Therapy for Patients With Diabetes, Received Statin Therapy	NCQA/HEDIS	Reporting Only	CY 2016	≥ 55.7%	CY 2017	≥ 57.73%	CY 2018
PQI 16: Lower-Extremity Amputation, Patients w/ Diabetes	AHRQ	≤2.4	CY 2016	≤ 2.4	CY 2017	≤ 2.4	CY 2018
Controlling High Blood Pressure	NCQA/HEDIS	≥49.9%*	CY 2016	≥ 46.9%*	CY 2017	QW	CY 2018
Statin Therapy for Patients With Cardiovascular Disease, Received Statin Therapy, Total	NCQA/HEDIS	Reporting Only	CY 2016	≥ 76.3%	CY 2017	QW	CY 2018
Annual Monitoring for Patients on Persistent Medication, Total	NCQA/HEDIS	Not Applicable	CY 2016	Not Applicable	CY 2017	Reporting Only	CY 2018
PQI 8: Heart Failure Admission Rate	AHRQ	Reporting Only	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018
PQI 13: Angina without Procedure Admission Rate	AHRQ	Reporting Only	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018
Medication Management for People With Asthma – Medication Compliance 50%, Total Rate; Medication Compliance 75 %, Total Rate	NCQA/HEDIS	50% Total Rate Not Applicable	CY 2016	50% Total Rate Reporting Only	CY 2017	50% Total Rate Reporting Only	CY 2018
		75% Total Rate ≥ 23.7%		75% Total Rate ≥ 25.1%		75% Total Rate ≥ 19.97%	
PDI 14: Asthma Admission Rate (ages 2 - 17)	AHRQ	Reporting Only	CY 2016	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018	Eliminated Effective SFY 2018
Pharmacotherapy Management of COPD Exacerbation	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Dispensed Systemic Corticosteroid Within 14 days:	CY 2018

APPENDIX A—MMC QUALITY MEASURES AND STANDARDS

Measure	Measurement Set	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
						Reporting Only**	
						Dispensed a Systemic Bronchodilator within 30 days: Reporting Only	
Quality Strategy Population Stream: Healthy Adults							
Cervical Cancer Screening	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	QBA ≥ 38.36	CY 2018
Breast Cancer Screening	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	QBA ≥ 43.68	CY 2018
Adult BMI Assessment	NCQA/HEDIS	Not Applicable	Not Applicable	Reporting Only	CY 2017	≥ 28.79	CY 2018
Adults' Access to Preventive/Ambulatory Health Services – Total	NCQA/HEDIS	≥79.6%	CY 2016	≥ 77.2%	CY 2017	≥76.17%	CY 2018
Tobacco Use: Screening and Cessation	AMA-PCPI	Not Applicable	Not Applicable	Reporting Only	CY 2017	Reporting Only**	CY 2018
Adult Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/HEDIS/CAHPS	≥2.3	CY 2016 (Survey conducted in CY 2017)	≥ 2.37	CY 2017 (Survey conducted in CY 2018)	≥ 2.35	CY 2018 (Survey conducted in CY 2019)
Adult - Customer Service Composite (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS	Not Applicable	Not Applicable	≥ 2.48	CY 2017 (Survey conducted in CY 2018)	≥ 2.48	CY 2018 (Survey conducted in CY 2019)
Ambulatory Care-Emergency Department (ED) Visits	NCQA/HEDIS	Reporting Only	CY 2016	Reporting Only	CY 2017	Reporting Only	CY 2018

APPENDIX A—MMC QUALITY MEASURES AND STANDARDS

Measure	Measurement Set	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year
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*This Minimum Performance Standard and associated measure are used in the Pay for Performance (P4P) Incentive System for the respective year listed in Table 1 above, and as outlined in Appendix O. No penalty will be assessed for noncompliance with this Minimum Performance Standard and measure for the corresponding year.

Note: no standard will be established or compliance assessed for the measures designated 'reporting only' or 'QW' in the Minimum Performance Standard column for the corresponding year.

** = Minimum Performance Standard will be established for the subsequent state fiscal year

TBD= Minimum Performance Standard: to be determined

QBA = Quality-Based Auto-Assignment measure

QW = Quality Withhold measure

APPENDIX B—MCOP QUALITY MEASURES AND STANDARDS

APPENDIX B—MCOP QUALITY MEASURES AND STANDARDS

MCOP SFY 2016, SFY 2017, SFY 2018, and SFY 2019 Performance Measures, Measurement Sets, Standards, and Measurement Years

Quality Strategy: Population Stream	Measure	Measurement Set	Applicable Population	SFY 2016 Minimum Perf. Std.	SFY 2016 Measurement Year	SFY 2017 Minimum Perf. Std.	SFY 2017 Measurement Year	SFY 2018 Minimum Perf. Std.	SFY 2018 Measurement Year	SFY 2019 Minimum Perf. Std.	SFY 2019 Measurement Year	SFY 2020 Minimum Perf. Std.	SFY 2020 Measurement Year
Behavioral Health	Follow-up After Hospitalization for Mental Illness -30 Day Follow Up**	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	N/A	≥ 41.2%	CY 2016	≥56.0%	CY 2017	TBD	CY 2018	TBD	CY 2019
Behavioral Health	Follow-Up After Hospitalization for Mental Illness - 7 Day Follow Up	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 23.0%	CY 2015	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA
Behavioral Health	Anti-depressant Medication Management	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	N/A	Effective Acute Phase Treatment ≥62.8%	CY 2016	Effective Acute Phase Treatment ≥ 64.1%	CY 2017	TBD	CY 2018	TBD	CY 2019
					Effective Continuation Phase Treatment: ≥47.4%	Effective Continuation Phase Treatment ≥ 48.4%							
Chronic Conditions	Controlling High Blood Pressure **	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 58.9%	CY 2015	≥ 47.0%	CY 2016	≥53.0%	CY 2017	TBD	CY 2018	TBD	CY 2019
Chronic Conditions	Comprehensive Diabetes Care - HbA1c Control (<8.0%)	NCQA/HEDIS	Dual Benefits Members (Opt-In)	N/A	CY 2015	≥ 58.3%	CY 2016	≥55.8%	CY 2017	TBD	CY 2018	TBD	CY 2019
Chronic Conditions	Part D Medication Adherence for Diabetes Medications**	CMS	Dual Benefits Members (Opt-In)	≥ 73.0%	CY 2015	≥ 69.0%	CY 2016	≥ 73.0%	CY 2017	TBD	CY 2018	TBD	CY 2019
Healthy Adults	Annual Flu Vaccine**	CAHPS	Dual Benefits Members (Opt-In)	≥ 69.0%	CY 2015 (Survey conducted in	≥ 63.0%	CY 2016 (Survey conducted	≥69.0%	CY 2017 (Survey conducted	TBD	CY 2018	TBD	CY 2019

APPENDIX B—MCOP QUALITY MEASURES AND STANDARDS

					CY 2016)		in CY 2017)		in CY 2018)				
Healthy Adults	Fall Risk Management – Managing Fall Risk **	NCQA/HEDIS/HOS	Dual Benefits Members (Opt-In)	≥ 55.0%	CY 2015 (Survey conducted in CY 2016)	≥ 53.0%	CY 2016 (Survey conducted in CY 2017)	≥55.0%	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018	TBD	CY 2019
Healthy Adults	Breast Cancer Screening	NCQA/HEDIS	Dual Benefits Members (Opt-In)	NA	CY 2015	≥ 66.0%	CY 2016	≥66.3%	CY 2017	TBD	CY 2018	TBD	CY 2019
Integrating Care	Plan All Cause Readmissions – Observed Readmissions (Num/Den)	CMS	Dual Benefits Members (Opt-In)	N/A	CY 2015	≤ 11.0%	CY 2016	≤ 11.0%	CY 2017	TBD	CY 2018	TBD	CY 2019
	Adults’ Access to Preventive/Am bulatory Health Services	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 94.6%	CY 2015	≥ 94.0%	CY 2016	≥ 93.8%	CY 2017	TBD	CY 2018	TBD	CY 2019
	Getting Appointments and Care Quickly Composite*	CAHPS	Dual Benefits Members (Opt-In)	N/A	CY 2015 (Survey conducted in CY 2016)	≥ 74.0%	CY 2016 (Survey conducted in CY 2017)	≥ 73.0%	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018	TBD	CY 2019
	Satisfaction with Customer Service Composite*	CAHPS	Dual Benefits Members (Opt-In)	N/A	CY 2015 (Survey conducted in CY 2016)	≥ 85.0%	CY 2016 (Survey conducted in CY 2017)	≥ 86.0%	CY 2017 (Survey conducted in CY 2018)	TBD	CY 2018	TBD	CY 2019
	Care for Older Adults - Medication Review 66 &	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 71.0%	CY 2015	≥ 60.0%	CY 2016	≥57.0%	CY 2017	TBD	CY 2018	TBD	CY 2019
	Care for Older Adults - Functional Status	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 59.0%	CY 2015	≥ 54.0%	CY 2016	≥56.0%	CY 2017	TBD	CY 2018	TBD	CY 2019
	Care for Older Adults - Pain Assessment	NCQA/HEDIS	Dual Benefits Members (Opt-In)	≥ 60.0%	CY 2015	≥ 62.0%	CY 2016	≥59.0%	CY 2017	TBD	CY 2018	TBD	CY 2019

APPENDIX B—MCOP QUALITY MEASURES AND STANDARDS

Improving and Rebalancing Long-TermCare	Nursing Facility Diversion Measure***	Ohio-Specific	Dual Benefits Members (Opt-In) and Medicaid - Only Members (Opt-Out)	≥5% decrease from CY 2013 (baseline year)	CY 2015	TBD	CY 2016	TBD	CY 2017	TBD	CY 2018	TBD	CY 2019
	Long Term Care Rebalancing Measure	Ohio-Specific	Dual Benefits Members (Opt-In) and Medicaid - Only Members	≥5% increase from CY 2013 (baseline year)	CY 2015	TBD	CY 2016	TBD	CY 2017	TBD	CY 2018	TBD	CY 2019
	Long Term Care Overall Balance Measure**	Ohio-Specific	Dual Benefits Members (Opt-In) and Medicaid - Only Members (Opt-Out)	≥5% decrease from CY 2013 (baseline year)	CY 2015	TBD	CY 2016	TBD	CY 2017	TBD	CY 2018	TBD	CY 2019
	Percent of residents whose need for help with daily activities has increased	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid - Only Members (Opt-Out)	≤ 15.2%	CY 2015	≤ 17.6%	CY 2016	≤ 17.6%	CY 2017	TBD	CY 2018	TBD	CY 2019
	Percent of residents who were physically restrained	RTI International/MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members	≤ 2.1%	CY 2015	≤ 2.1%	CY 2016	≤ 2.1%	CY 2017	TBD	CY 2018	TBD	CY 2019

APPENDIX B—MCOP QUALITY MEASURES AND STANDARDS

			(Opt-Out)										
	Percent of residents experiencing on or more falls with a major injury	RTI International/ M DS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 3.6%	CY 2015	≤ 3.6%	CY 2016	≤ 3.6%	CY 2017	TBD	CY 2018	TBD	CY 2019
	Percent of residents with urinary tract infection	RTI International/ M DS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 5.8%	CY 2015	≤ 5.8%	CY 2016	≤ 5.8%	CY 2017	TBD	CY 2018	TBD	CY 2019
	Percent of high-risk residents with pressure ulcers	RTI International/ M DS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 5.6%	CY 2015	≤ 5.6%	CY 2016	≤ 5.6%	CY 2017	TBD	CY 2018	TBD	CY 2019
	Percent of residents who have/had a catheter inserted and left in their bladder	RTI International/ M DS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	≤ 3.0%	CY 2015	≤ 3.0%	CY 2016	≤ 3.0%	CY 2017	TBD	CY 2018	TBD	CY 2019

* Quality withhold measure for Demonstration Year 1 (CY 2014 and CY 2015).

** Quality withhold measure for Demonstration Years 2 (CY 2016) and 3 (CY 2017)

APPENDIX C—QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)
SUBMISSION REQUIREMENTS

APPENDIX C—QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) SUBMISSION REQUIREMENTS

Introduction

As required by 42 CFR 438.330 and the Ohio Medicaid and MyCare Managed Care Provider Agreements, each MCP must annually submit its Quality Assessment and Performance Improvement (QAPI) Program which describes its systematic approach for assessing and improving the quality of care.

QAPI programs involve the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QA specifies standards for service and outcome quality and provides a process for assuring that those standards are met. QA is on-going and is both anticipatory and retrospective in its assessment of organizational performance, including identification of where and why performance may be at risk or has failed to meet standards. QA's counterpart, PI (and QI) refers to the organization's continuous, ongoing efforts to achieve measurable improvements in equity and population health. Improvement efforts are deliberate and defined processes that focus on identifying areas of opportunity and testing new approaches for addressing the root causes of problems and barriers to improvement.

The MCP's QAPI, therefore, amounts to much more than compliance with Federal statute or regulation; it represents an ongoing, organized method of doing business to achieve optimum results, involving all levels of the organization and informing both the organization's and the State's approach to improving the health of Ohioans.

MCP's are required to submit annual updates to the QAPI, which reflect on-going efforts to improve health and health equity within the key population streams of ODM's Quality Strategy. These updates are used to help evaluate the overall Medicaid improvement strategy and provide direction for future efforts. The QAPI ensures the delivery of quality health care services by establishing strategic goals and objectives, initiatives and interventions that support the MCP's goals, and evidence-based policies and procedures.

APPENDIX C—QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) SUBMISSION REQUIREMENTS

Instructions

The QAPI and its accompanying submission requirements are divided into seven (7) separate components.⁵

Component 1: Program Accountability;

Component 2: Clinical Practice Guidelines;

Component 3: Healthcare Service Utilization;

Component 4: Quality and Appropriateness of Care Delivered to Enrollees with Special Healthcare Needs and Enrollees Receiving Long-term Services and Supports;

Component 5: Addressing Health Disparities & Cultural Considerations;

Component 6: Improvement Projects;

Component 7: [Annual Written Evaluation of Impact and Effectiveness of the QAPI program and Improvement Strategy Update](#)

Comprehensive Submissions:

All seven (7) components must be submitted to Melissa.Nance@medicaid.ohio.gov within the Performance Improvement Unit of the Bureau of Health Research and Quality Improvement on or before **November 15, 2016** (the initial submission year) and every subsequent three years.

Annual Submissions

The Annual QAPI Submission includes a focused review of Component 7 (Annual Written Evaluation of Impact and Effectiveness of QAPI program and Improvement Strategy Update). Where applicable, updates should be provided for each of the key population streams of the Medicaid Quality Strategy: Women of Reproductive Age; Chronic Conditions; Behavioral Health; Healthy Children and Healthy Adults.

Other program components which have had substantial changes or updates during the preceding year⁶ should be submitted on an annual basis with the annual QAPI update.

⁵ Please note: the components have been re-ordered since the initial submission in an attempt to reduce repetitiveness and increase the logical flow of information submitted.

⁶ Substantial changes include, but are not limited to: changes in coverage or population served; changes to QAPI program senior leadership and oversight; changes in QI training or administration of the QI program; the addition or deletion of an improvement project; changes in thresholds for utilization management; changes to how the MCP defines members with special health care needs or changes to the MCPs assessment of quality and appropriateness of care; changes in efforts to reduce health disparities and to increase cultural competency; and changes in how the MCP applies adopted clinical

APPENDIX C—QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) SUBMISSION REQUIREMENTS

As previously noted, ***changes to QAPI Program contact information must be submitted within 90 days of the change.***

The MCP must clearly and completely respond to each question in the attached template. The responses should be able to “stand alone” and should be consistent with, and supported by, the MCP’s source documents. References to supporting documentation should be provided in each response, as applicable, with clear identification of the document title, page, section, etc. Failure to provide supporting documentation will result in the component being considered as incomplete and a resubmission will be required.

The MCP must oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor. If any services are delegated, specify the responsibilities of all parties involved when replying to the question.

guidelines. Updates regarding implementation or results of initiatives in the planning phase during the previous submission should also be included in annual updates.

QAPI Program Contact Information⁷

MCP Name: Choose an item.

MCP Contact Person(s):

Telephone Number(s):

Email(s):

Date Submitted: Click here to enter a date.

Type of Submission: Choose an item.

If this is an Annual Supplement, please include:

- Section(s) Updated:
- Supplement Version Date: Click here to enter a date.

⁷ Changes to QAPI program contact information should be updated 90 days subsequent to the change.

QAPI Components

Component 1: QAPI Program Accountability, Program Staffing, & Oversight

Updates to Component 1 are required when there has been a substantial change in program accountability, staffing, and oversight. Each MCP is required to establish appropriate administrative oversight and accountability arrangements for the QAPI Program. Please include the information below when describing the MCP’s QAPI program accountability, staffing and oversight.

Describe the Quality Program’s organizational and governance structure, including the following components:

A. Position(s) with overall responsibility for the QAPI;

B. Brief descriptions of senior level QI leadership team structure, including:

1. Position of each member of the senior level QI leadership team within the MCP,
2. Role(s) on the senior level QI leadership team,
3. Responsibilities on the senior level QI leadership team,
4. Quality improvement training and experience,
5. The role of each team member in the quality improvement process,
6. Structure for ensuring dedicated analytic and project management support,
7. Methods for identifying and assigning needed quality improvement resources, and
8. Methods for building and sustaining quality improvement culture and capacity throughout the organization;

C. Table of Organization (TO), including:

1. Reporting relationships of key Quality Program staff and QI committees,
2. Date of last update, and
3. Frequency with which TO is reviewed and updated;

D. Improvement Project Staff and QI Committee Membership, including *(Note: QI teams shall be composed of MCP staff dedicated to the Ohio line of business and empowered to promote improved MCP operations that represent required areas noted in the current Provider Agreement):*

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1. Staff Name,
2. Position Title (e.g., Medical Director, QI Director, Case Management Team Lead, Analyst),
3. Credentials (e.g., education, training, licenses),
4. Area of expertise (e.g. quality improvement, analytics, subject matter expertise, health equity, etc.),
5. Population health focus, including population streams (e.g., Women’s Health; Chronic Conditions; Behavioral Health)
6. Role on committees (if applicable)
 - a. Committee name (e.g., Healthcare Utilization, Quality Assessment and Performance Improvement (QAPI), member services, provider relations, and delegation),
 - b. Committee function (reviewing results of QAPI evaluation activities, assuring that appropriate action is taken with regard to evaluation findings),
 - c. Individual’s committee role (member, Chair, Co-chair), and
 - d. Committee meeting frequency;
7. QI Responsibilities (e.g., Integrating quality throughout the organization; process improvement, facilitation, project management, analytical support, health equity, administrative support); *Note: Please include all responsibilities outlined in the Ohio Medicaid Managed Care Provider Agreement (e.g., Medical Director must serve as the director of the Utilization Management committee and chair or co-chair the Quality Assessment and Performance Improvement committee and be involved in all clinically-related projects.)*

Completion of the table below may substitute for narrative descriptions of QI staff roles and responsibilities.

Name	Position Title	Credentials	Leadership area(s)	Population focus	QI Committees, Committee Functions, Committee Role(s), & Meeting Frequency	QI Responsibilities

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Name	Position Title	Credentials	Leadership area(s)	Population focus	QI Committees, Committee Functions, Committee Role(s), & Meeting Frequency	QI Responsibilities

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Name	Position Title	Credentials	Leadership area(s)	Population focus	QI Committees, Committee Functions, Committee Role(s), & Meeting Frequency	QI Responsibilities

- E. Describe the MCP’s provision for ongoing communication and coordination between the area that oversees the QAPI program and relevant functional areas of the organization, including the following:**
- a. Framework for frequently and transparently sharing data and information throughout the organization to identify and inform improvement activities (e.g. dashboards; newsletters; staff meetings),
 - b. Mechanisms used to frequently, transparently, and proactively communicate improvement status updates and results across the organization and to executive leadership,
 - c. Mechanisms for line level staff engaged in plan operations to identify areas for improvement and share their ideas with the senior QI leadership team,
 - d. Mechanisms for proactive, regular communication with ODM and/or EQRO staff regarding improvement opportunities and priorities, successes, lessons learned, and future activities,

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- e. Mechanisms for intra- and inter-organizational collaboration to further ODM and plan-specific quality goals,
 - f. Analysis of data to identify disparities in services and/or care and identification of interventions for specific populations when needed, and
 - g. Active incorporation of member and provider perspectives into improvement activities;
- F. Describe the MCP’s strategy for ensuring that all staff responsible for the QAPI Program will remain current in the education, experience, and training needed for their positions. Include the following QI coursework content, as well as how these requirements will be met continually and consistently:**
- a. The Model for Improvement⁸,
 - b. Edward W. Deming’s System of Profound Knowledge,
 - c. Listening to and incorporating the Voice of the Customer (VOC),
 - d. Process mapping,
 - e. SMART Aim development,
 - f. Methods for barrier identification and intervention selection (e.g. root cause analysis, Pareto charts, failure mode and effects analysis, the 5 whys technique, etc.),
 - g. Selection and use of process, outcome and balancing measures,
 - h. Testing change through the use of PDSA cycles,⁹
 - i. The use of statistical process control, such as the Shewart control chart¹⁰
 - j. Tools for spread and sustainability planning;

Note regarding coursework completion: Training curricula for staff outlined in the Provider agreement shall be submitted to ODM for approval prior to enrollment. Evidence of coursework completion shall be submitted within one (1) month of completion.

⁸ Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

⁹ Deming, WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000

¹⁰ Revelle, JB. *Quality Essentials: A Reference Guide from A to Z*. ASQ Quality Press, 2004

G. Describe the MCP’s strategy for promulgating QI knowledge and application of QI principles throughout the organization, including:

1. Specific timelines for obtaining training in the application of QI principles to all staff within the organization,
2. How the organization will meet minimum requirements for completion of course work in the application of rapid cycle quality improvement tools and methods from an ODM-approved entity,¹¹
3. How the organization will identify additional training needs, and
4. How the organization will ensure that new staff are trained in and can apply QI principles.

Note regarding coursework: Training must include the following staff at minimum: MCP Medical Directors, Quality Improvement Directors, Analytic support staff, and at least MCP staff person assigned to each improvement team.

Component 2: Clinical Practice Guidelines

A. Describe how the MCP will ensure that the adopted guidelines will:

1. Be based on valid and reliable clinical evidence or a consensus of healthcare professionals in a particular field. Cite examples of the entities (e.g., governing body/bodies, professional medical associations, health organizations, etc.) from which the guidelines will be adopted;
2. Consider the needs of the members when adopting the guidelines;
3. Be adopted in consultation with the MCP’s contracting healthcare professionals, include:
 - a) *Specialties involved in consultation,*
 - b) *How consultation was achieved, and*
 - c) *The organization’s consideration of comments from practitioners to whom guidelines were circulated; and*
4. Be reviewed (including the frequency) and updated as appropriate;

¹¹ Examples of approved entities offering coaching and/ or training in these areas include: the Institute for Healthcare Improvement, the Intermountain Healthcare Leadership Institute, The Cincinnati Children’s Hospital Anderson Center for Health System Excellence, the American Society for Quality’s Learning Institute, the Deming Institute, and the National Association for Healthcare Quality.

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- B. Describe the method(s) that will be used to provide guidelines to all affected providers and to members and potential members, when requested.**
- C. Describe how the MCP will apply the adopted guidelines in making decisions for:**
 - 1. Utilization management,
 - 2. Member education,
 - 3. Coverage of services, and
 - 4. Other areas in which the guidelines apply.

Component 3: Healthcare Service Utilization

Describe how the Utilization Management program is monitored to detect and correct potential under- and over-utilization of services, including:

- A. How thresholds for selected types of utilization are set (e.g., clinical criteria);**
- B. How frequently data is compared to established thresholds to detect under- and over-utilization;**
- C. The mechanisms in place to detect under-and over-utilization of services, as well as service denials, specifically:**
 - 1. The reports and data sources that will be used to monitor utilization,
 - 2. The categories of service that will be reviewed; and
 - 3. The frequency with which this will occur;
- D. Describe how the MCP will identify trends that must be addressed (e.g., examine possible explanations for all data not within thresholds; analyze data not within threshold by medical group or practice);**
- E. Take actions to address identified problems of under- and over-utilization and measure the effectiveness of interventions;**
- F. Describe how UM information will be used to inform QI activities;**

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- G. How the timeliness of UM decisions is defined;**
- H. How local delivery system and individual circumstances are taken into account when determining appropriateness of services;**
- I. How the consistency of the application of UM criteria is evaluated;**
- J. What methods are in place to ensure that the UM decision-making process is as efficient and uncomplicated as possible for the member, the practitioner, and/or the health delivery organization’s staff? Include, at a minimum:**
 - 1. Why the method was chosen,
 - 2. The measures used to assess how the UM process impacts the member and provider,
 - 3. The thresholds that are set,
 - 4. The mode of assessment,
 - 5. How frequently the burden of UM is assessed, and
 - 6. Timeliness of response when a need for process streamlining has been determined.

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Component 4: Quality and Appropriateness of Care Delivered to Enrollees with Special Healthcare Needs and Enrollees Receiving Long-term Services and Supports

Describe the mechanisms that will be used to assess the quality and appropriateness of care provided to members with special health care needs, including:

- A. How the MCP defines and identifies members with special health care needs** (e.g., specific diagnoses, costs thresholds, pharmacy utilization factors, etc.);
- B. Assessment methods and frequency;**
- C. How the MCP establishes standards for assessing quality and appropriateness of care** (e.g., accessibility standards for preventive, non-symptomatic care; routine, non-urgent symptomatic care; urgent medical care; after hours care; emergency medical care and routine office visits) **to members with special health care needs;**
- D. How the MCP establishes standards for assessing quality and appropriateness of care** (e.g., accessibility standards for preventive, non-symptomatic care; routine, non-urgent symptomatic care; urgent medical care; after hours care; emergency medical care and routine office visits) **to members receiving long-term services and supports, including:**
 - 1) How transitions of care are assessed, and
 - 2) Comparison of services received with those set forth in the members treatment/care/service plan, and
 - 3) How the MCP participates in efforts by the state to prevent, detect and remediate critical incidents
- E. How findings are incorporated into quality improvement efforts; and**
- F. MCP plans for improvement in this area.**

Component 5: Addressing Health Disparities and Increasing Organizational Cultural Competency

Disparities exist when differences in health outcomes or health determinants are observed between populations. These differences are closely linked with social, economic, and/or environmental disadvantage and negatively impact groups of people who have systematically

APPENDIX C—QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) SUBMISSION REQUIREMENTS

experienced greater obstacles to health due to historical discrimination or exclusion (e.g., racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location)^{12,13}

Assessing disparities allows efforts to be focused where they are most needed while also allowing for a determination of whether strategies are successful in achieving progress over time.

Building cultural competency is one strategy for reducing disparities and achieving health equity. In culturally competent organizations, the importance of culture is recognized and incorporated at all levels, cross-cultural relations are assessed, dynamics resulting from cultural differences are recognized and attended to, cultural knowledge is expanded, and services are adapted to meet culturally unique needs. A culturally competent system also includes a mindfulness of how different patient populations' health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes intersect and influence one another.¹⁴

A. Provide a description of current and planned efforts initiated independently¹⁵ by the MCP to track and reduce health disparities, including:

1. Clinical or non-clinical topic area,
2. Geographic area,
3. Community and clinical partners,
4. Specific process and outcome measures with baseline, goal, and target date (SMART Aims), and
5. Assessment tools used to determine progress;

¹² U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 4/11/2016]. Available from: http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf.

¹³ Centers for Disease Control and Prevention. Introduction: CDC Health Disparities and Inequalities Report — United States, 2013. MMWR 2013; 62 (Suppl 3):3.

¹⁰ Lavizzo-Mourey R, Mackenzie E: Cultural competence: an essential hybrid for delivering high quality care in the 1990's and beyond. Trans Am Clin Climatol Assoc 1996; VII: 226-38.

¹⁵ If efforts that have been initiated by ODM are listed please note that they are in partnership with ODM rather than independently initiated by the MCP.

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B. Describe how the MCP will promote (both internally and externally) the delivery of services in a culturally appropriate and effective manner to all members. Include in your answer:

1. Strategies to be used by the MCP to recruit, retain, and promote (at all levels of the organization) a diverse staff and leadership that are representative of the demographic profile of the service area;
2. How the MCP will ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery;
3. How the MCP will measure and track whether services are being delivered in a culturally effective manner;
4. How the MCP will track whether there are gaps within the provider network in meeting members' spoken linguistic needs or requests for health care delivery; and
5. Whether the health plan has obtained or is actively pursuing the National Committee for Quality Assurance's (NCQA) Multicultural Health Care distinction

Component 6: Improvement Projects

Each MCP is required to conduct Quality Improvement Projects (QIPs) and Performance Improvement Projects (PIPs) in clinical and nonclinical areas using quality improvement science techniques that are designed to achieve improvements in health outcomes, quality of life, and satisfaction for providers and members. In order to provide a comprehensive picture of MCP efforts, this section should include the full portfolio of the MCP's improvement projects for the Ohio Medicaid and MyCare populations. Although ODM-initiated improvement efforts should be included, this section should not be limited to ODM initiated projects. This section should clearly show how the MCP's portfolio of projects aligns with and influences the MCP's strategic efforts.

For each improvement project, include the following:

- A. The improvement project topic, expressed as a Specific, Measureable, Actionable, Realistic, and Time-bound (SMART) aim;**
- B. How the topic is connected to the ODM Quality Strategy (e.g., population stream, payment innovation, health equity, etc.)¹⁶,**
- C. How the topic is connected to the MCP's Ohio Quality Strategy,**

¹⁶ For reference, the ODM Quality Strategy can be found on the Medicaid website at: <http://www.medicaid.ohio.gov/MEDICAID101/QualityStrategyandMeasures.aspx>

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- D. Key driver diagram (or other cause and effect diagram) showing the theory of improvement or how the interventions being tested are thought to impact the project goal (SMART Aim);**
- E. How the voice of the customer (member, provider, etc.) was ascertained and incorporated into topic choice and/or theory of improvement;**
- F. Methods used to identify key drivers, associated interventions, and prioritization of interventions (e.g., process mapping, Pareto analyses, root cause analyses, FMEAs, Gemba walk);**
- G. Examples of intervention tests (PDSAs) and lessons learned;**
- H. Objective quality indicators used to measure performance, including:**
 - 1. Whether the measure is a process measure, an outcome measure, or balancing measure,
 - 2. Data source(s) for the measure,
 - 3. The intervention or driver to which the measure is linked,
 - 4. The frequency of measurement,
 - 5. The frequency of review of longitudinal (time series) measurement data, and
 - 6. What methods are used to draw conclusions from the data (e.g., identification of special cause or the degree of variance in processes);
- I. Longitudinal (trended) depictions (run charts, control charts, line graphs) of the MCPs improvement project outcomes over time with annotation of intervention periods and special cause identification;**
- J. How results and lessons learned from performance and quality improvement projects are communicated within and across the organization, as well as integrated into the overall QAPI program;**
- K. Mechanisms for communicating results and lessons learned from performance and quality improvement projects with ODM;**
- L. Systems, processes or procedures that have been or will be put in place to sustain and spread successful interventions.**

APPENDIX C—QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) SUBMISSION REQUIREMENTS

Component 7: Annual Written Evaluation of Impact and Effectiveness of QAPI program and Improvement Strategy Update

To fulfill the requirements of component 7, the MCP should submit the annual evaluation of its quality strategy, as well as the following information:

- A. The planning timeline for the MCP’s QAPI program. The timeline should include, at minimum:
 - 1. Date ranges for internal evaluation of performance results,
 - 2. Date ranges for quality strategy development, leadership review and finalization, and
 - 3. Other dates that may help increase ODM’s understanding of the MCPs QAPI program at the time of submission.
- B. The roles of contracted providers, MCP leadership, members, and stakeholders in the evaluation of the MCP’s QAPI program;
- C. The MCP’s methods for evaluating the impact and effectiveness of its QAPI;
- D. A summary of lessons learned and intervention successes in improving the quality of MCP services during the past year, including the results from any efforts to support community integration for members using long-term services and supports;
- E. How “lessons learned” through the QAPI evaluation were used to update the QI strategy and will influence the MCP’s QAPI;
- F. Methods other than the QAPI evaluation that influenced the MCP’s updated QI strategy;
- G. QAPI areas identified as needing to be restructured or changed in the upcoming year;
- H. The MCP current strategic improvement priorities and prioritization criteria;
- I. How the MCP’s strategic priorities tie back to the ODM Quality Strategy;
- J. Measures that will be used to assess the success of the updated QI strategy, including:

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1. How measures tie back to prioritized areas,
 2. Measure baselines, and
 3. Measure targets;
- K. How the identification of improvement opportunities is encouraged throughout the organization;
- L. How the MCP ensures the maintenance and spread of successful interventions;
- M. Which interventions tested could have the largest impact on the health of Ohioans if spread state-wide.

APPENDIX D--DEEMING REVIEW

March 2020

Ohio Medicaid Managed Care

Deeming Evaluation

State Fiscal Year 2020



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Acknowledgements, Acronyms, and Initialisms¹⁷

BBA.....	Balanced Budget Act of 1997
CFR.....	Code of Federal Regulations
CMS.....	Centers for Medicare & Medicaid Services
EQR/EQRO.....	External Quality Review/EQR Organization
MCOP.....	MyCare Ohio Plan
MCP.....	Managed Care Plan
NCQA.....	National Committee for Quality Assurance
OAC.....	Ohio Administrative Code
ODM.....	Ohio Department of Medicaid
PA.....	Provider Agreement
Qsource®.....	a registered trademark
SFY.....	State Fiscal Year

¹⁷ Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.

Overview

The *Balanced Budget Act of 1997* (BBA) requires states contracting with managed care plans (MCPs) for the provision of healthcare services to Medicaid beneficiaries to comply with the regulations outlined in the *Code of Federal Regulations* (CFR), Title 42, Public Health, Part 438, Managed Care. States must ensure that they arrange for annual, external, independent reviews of the quality, timeliness, and accessibility of services provided by MCPs to enrolled consumers.

These reviews are to be performed by an external quality review organization (EQRO). The Ohio Department of Medicaid (ODM) has contracted with Qsource to perform some of these federally required EQR activities for MCPs and MyCare Ohio Plans (MCOPs) (referred to hereinafter as plans) contracted by ODM to provide healthcare benefits to Medicaid recipients in the state of Ohio.

Codified in 42 CFR § 438.358, one of the mandatory EQR activities is a comprehensive administrative review within the previous three-year period to determine if each plan is compliant with federal requirements. ODM's comprehensive administrative review includes federal requirements, relevant *Ohio Administrative Code* (OAC) requirements, and applicable provisions included in ODM's Medicaid/MyCare Managed Care Provider Agreement (PA). These cover the areas outlined in **Table 1**.

Table 1. Comprehensive Administrative Review Standards

Standard	CFR Citation	CFR Title
1. Access and Availability of Services	438.206	Availability of services
	438.207	Assurances of adequate capacity and services
2. Grievance System	438.402	General requirements
	438.404	Timely and adequate notice of adverse benefit determination
	438.406	Handling of grievances and appeals
	438.408	Resolution and notification: Grievances and appeals
	438.410	Expedited resolution of appeals
	438.414	Info about the grievance appeal system to providers and subcontractors
	438.416	Recordkeeping and reporting requirements
	438.420	Continuation of benefits during appeal and the State fair hearing pending
438.424	Effectuation of reversed appeal resolutions	

Table 1. Comprehensive Administrative Review Standards

Standard	CFR Citation	CFR Title
3. Quality Assessment and Performance Improvement	438.330	Quality assessment and performance improvement program
	438.236	Practice guidelines
	438.242	Health information systems
4. Coordination and Continuity of Care	438.208	Coordination and continuity of care
5. Coverage and Authorization of Services	438.210	Coverage and authorization of services
	438.114	Emergency and post-stabilization services
6. Subcontractual Relationships and Delegation	438.230	Subcontractual relationships and delegation
7. Member Information	438.10	Information requirements
8. Member Rights and Protections	438.100	Member rights
	438.102	Provider–member communication
	438.104	Marketing activities
	438.106	Liability for payment
	438.108	Cost sharing
	438.224	Confidentiality
9. Credentialing	438.206 (b)(6)	Availability of services
	438.214	Provider selection
10. Disenrollment	438.56	Disenrollment: Requirements and limitations

Per 42 CFR § 438.360, non-duplication of mandatory activities (known as deeming), a state may use information about the plan obtained from a private accreditation review to avoid duplication in the EQR activities. ODM elected to apply the deeming option for the state fiscal year (SFY) 2020 comprehensive administrative review and tasked Qsource with performing a review to ensure that federal regulations for applying the non-duplication of mandatory activities are followed. To apply the deeming option, the following conditions must be met:

- ◆ The plan is in compliance with the applicable Medicare Advantage standards established by the Centers for Medicare & Medicaid Services (CMS), as determined by CMS or its contractor for Medicare, or had obtained accreditation from a private accrediting organization recognized by CMS as applying standards at least as stringent as Medicare under the procedures in 42 CFR § 422.158.
- ◆ The review standards are comparable to standards established through the EQR protocols (42 CFR § 438.352) for the EQR activities established in 438.358(b)(1)(i-iii).

- ◆ The plan provides to the State, and its EQR, all reports, findings, and other results of Medicare or private accreditation review activities applicable to the standards for EQR activities.
- ◆ The State must identify in its quality strategy the standards for which it will use information from a Medicare or private accreditation review and the rationale for why it is duplicative.

Methodology for Determining Comparability

To perform the deeming review, Qsource obtained the National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans for 2017 and 2018. Based on NCQA's accreditation process, plans undergo the compliance with standards review once every third year, and plan accreditation cycles vary. Therefore, Qsource considered the year each plan received its last accreditation on the standards to determine the applicability of deeming.

Qsource reviewed the accreditation standards for 2017 and 2018, and evaluated which CFRs were comparable to areas noted in **Table 2**.

Contracted Managed Care Plan	Program/ Product Line	Submission	Accreditation Effective	Standards Year
Aetna	Medicare/HMO	12-05-17	02-13-18	2017
Molina Healthcare of Ohio, Inc.	Medicaid/HMO	12-01-17	02-01-18	2017
UnitedHealthcare Community Plan of Ohio	Medicaid/HMO	10-17-17	12-29-17	2017
Buckeye Health Plan	Medicaid/HMO	01-03-19	03-18-19	2018
CareSource	Medicaid/HMO	06-19-18	10-01-18	2017
Paramount	Medicaid/HMO	01-09-18	04-17-18	2017

Qsource developed a deeming crosswalk that included the applicable CFR and ODM requirements compared to applicable NCQA standards/elements to determine whether the NCQA standards/elements were at least as stringent as the CFR and/or ODM requirements. The CFR and ODM requirements that Qsource determined comparable to NCQA accreditation standards were identified as eligible for deeming. NCQA standards/elements similar to the CFR and ODM contract requirements, but not as stringent, were noted as ineligible for deeming. A comment to clarify the rationale for the determination was included in the deeming crosswalk.

Findings

Qsource compared the CFRs with the NCQA standards in 2017 and 2018. The current review for SFY 2020 compared each standard in the CFR with the NCQA standards to determine if any of the current standards produced 100% comparability with the CFR. **Table 3** provides a summary of the findings from the current SFY 2020 review of standards.

Table 3. SFY 2020 Deeming Results: Comparable Elements		
	2017	2018
Access and Availability of Services	4	5
Grievance System	3	13
Quality Assessment and Performance Improvement	0	3
Coordination and Continuity of Care	0	5
Coverage and Authorization of Services	5	6
Subcontractual Relationships and Delegation	0	0
Member Information	2	3
Member Rights and Protections	0	0
Credentialing	1	1
Disenrollment	0	0
Totals	15	36

Note: NCQA 2018 Standards and Guidelines for the Accreditation of Health Plans made the addition of a number of elements to the Medicaid (MED) standard. Due to these changes, the number of 100% comparable elements increased from 2017 to 2018. These elements align with CFR requirements, therefore facilitating deeming of a number of CFR provisions that could not be considered deemed in 2017.

Recommendations

Qsource recommends that all the Medicaid CFRs found to be 100% comparable with the NCQA standards be eligible for deeming during the SFY 2020 comprehensive administrative review of Ohio plans. In order for plans to be deemed an eligible standard, the following criteria must be met: 1) the plan scored 100% on the accreditation review element; and 2) there were no compliance issues on the deemed standard in CY 2019. Deemed elements will be displayed in the administrative compliance assessment tool showing that compliance was met through deeming.

Explanatory Notes

1. The foundation of the deeming crosswalk is the group of *Code of Federal Regulations* (CFR) provisions required by 42 CFR §438.358 (Subpart D and 42 CFR §438.330) effective 1/1/19. Each provision is grouped into a standard that includes provisions similar in nature/content. In addition, review of compliance with the following additional CFR provisions is included:
 - a. Subpart A – Member Information
 - b. Subpart B – State Responsibilities (Disenrollment)
 - c. Subpart C – Member Rights and Protections
2. In addition to CFR provisions, review of compliance with *Ohio Administrative Code* (OAC) and Provider Agreement (PA) provisions relevant to the CFR standards is incorporated.
3. Qsource deeming determination terms:
 - a. Deemable – The National Committee for Quality Assurance (NCQA) addresses all CFR, OAC, and PA criteria.
 - b. Not Deemable – NCQA does not address all CFR, OAC, and PA criteria.
 - c. NA – Not applicable.
4. **Table 1** includes a comprehensive list of the CFR provisions by standard to be reviewed for deeming.

Table 1. Code of Federal Regulations (CFR) Provisions by Standard				
Standard	Standard Name	CFR Subpart	CFR Citation	CFR Title
1	Access and Availability of Services	Subpart D – MCO, PIHP, and PAHP Standards	438.206	Availability of services
		Subpart D – MCO, PIHP, and PAHP Standards	438.207	Assurances of adequate capacity and services
2	Grievance System – Subpart D refers the reader to provisions in Subpart F	Subpart F - Grievance and Appeal System	438.402	General requirements
		Subpart F - Grievance and Appeal System	438.404	Timely and adequate notice of adverse benefit determination
		Subpart F - Grievance and Appeal System	438.406	Handling of grievances and appeals
		Subpart F - Grievance and Appeal System	438.408	Resolution and notification: Grievances and appeals
		Subpart F - Grievance and Appeal System	438.410	Expedited resolution of appeals
		Subpart F - Grievance and Appeal System	438.414	Information about the grievance and appeal system to providers and subcontractors
		Subpart F - Grievance and Appeal System	438.416	Recordkeeping and reporting requirements

2020 Comprehensive Administrative Review – Managed Care Plan (MCP) Deeming Review
National Committee for Quality Assurance (NCQA) Health Plan Accreditation – 2017 Accreditation Standards
NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and
Provider Agreement (PA) Provisions

Table 1. Code of Federal Regulations (CFR) Provisions by Standard

Standard	Standard Name	CFR Subpart	CFR Citation	CFR Title
		Subpart F - Grievance and Appeal System	438.420	Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending
		Subpart F - Grievance Appeal System	438.424	Effectuation of reversed appeal resolutions
3	Quality Assessment and Performance Improvement	Subpart E - Quality Measurement and Improvement: External Quality Review	438.330	Quality assessment and performance improvement program
		Subpart D - MCO, PIHP, and PAHP Standards	438.236	Practice guidelines
		Subpart D - MCO, PIHP, and PAHP Standards	438.242	Health information systems
4	Coordination and Continuity of Care	Subpart D - MCO, PIHP, and PAHP Standards	438.208	Coordination and continuity of care
5	Coverage and Authorization of Services	Subpart D - MCO, PIHP, and PAHP Standards	438.210	Coverage and authorization of services
		Subpart C - Member Rights and Protections	438.114	Emergency and post-stabilization services
6	Subcontractual Relationships and Delegation	Subpart D - MCO, PIHP, and PAHP Standards	438.230	Subcontractual relationships and delegation
7	Member Information	Subpart A - General Provisions	438.10	Information requirements
8	Member Rights and Protections	Subpart C - Member Rights and Protections	438.100	Member rights
		Subpart C - Member Rights and Protections	438.102	Provider–member communication
		Subpart C - Member Rights and Protections	438.104	Marketing activities
		Subpart C - Member Rights and Protections	438.106	Liability for payment
		Subpart C - Member Rights and Protections	438.108	Cost sharing
		Subpart D - MCO, PIHP, and PAHP Standards	438.224	Confidentiality
9	Credentialing	Subpart D – MCO, PIHP, and PAHP Standards	438.206(b)(6)	Availability of services
		Subpart D – MCO, PIHP, and PAHP Standards	438.214	Provider selection
10	Disenrollment	Subpart B – State Responsibilities	438.56	Disenrollment: Requirements and limitations

5. NCQA accreditation cycles for Ohio’s Medicaid managed care plans (MCPs) are included in [Table 2](#).



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Table 2. Managed Care Plan (MCP) Accreditation Cycles				
Contracted Managed Care Plan	Program/Product Line	Submission	Accreditation Effective	Standards Year
Aetna	Medicare / HMO	12-05-17	02-13-18	2017
Molina Healthcare of Ohio, Inc.	Medicaid / HMO	12-01-17	02-01-18	2017
UnitedHealthcare Community Plan of Ohio, Inc.	Medicaid / HMO	10-17-17	12-29-17	2017
Buckeye Health Plan	Medicaid / HMO	01-03-19	03-18-19	2018
CareSource	Medicaid / HMO	06-19-18	10-01-18	2017
Paramount	Medicaid / HMO	01-09-18	04-17-18	2017

NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

6. **Table 3** includes the deeming crosswalk between CFR provisions—combined with related OAC and/or PA provisions—and any applicable NCQA standard/element.

Table 3. Deeming Crosswalk for Managed Care Plans (MCPs) – 2017 Accreditation Standards								
CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
Standard 1: Access and Availability of Services								
42 CFR 438.206 – Access and Availability of Services								
438.206(b)(2)	Direct Access to Women's Health Specialist	Provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	MED 1A is comparable.	The organization allows women direct access to in-network women's health specialists for covered routine and preventive health care services.	Met	The MCP must permit members to self-refer to any women's health specialist within the MCP's panel for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist 42 CFR §438.206(b)(2) OAC 5160-26-03(H)(4) PA Appendix H-4(c)(ii)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.206(b)(3)	Second Opinion	Provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.	MED 1B is comparable.	The organization provides for a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. NCQA explanation includes that the second opinion must be available at no more cost to the member than if the service was obtained in-network.	Met	The MCP must provide for a second opinion from a qualified healthcare professional within the network or arrange for the member to obtain one outside the network, at no cost to the member. 42 CFR §438.206(b)(3) OAC 5160-26-03(D)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.

Table 3 (Cont.) Deeming Crosswalk for Managed Care Plans (MCPs) – 2017 Accreditation Standards

CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
Standard 1: Access and Availability of Services (cont.)								
42 CFR 438.206 – Access and Availability of Services								
	Out-of-Network Services	If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCP must adequately and timely cover these services out of network for the member, for as long as the MCP provider network is unable to provide them.	MED 1C is comparable.	If the organization is unable to provide a necessary and covered service to a member in-network, the organization must adequately and timely cover these services out of network for as long as the organization is unable to provide the service.	Met	If the network is unable to provide necessary and covered services, the MCP must adequately and timely cover these services for the member outside of the network for as long as the MCP network is unable to provide the covered services. 42 CFR §438.206(b)(4) OAC 5160-26-03(A)(5) PA Appendix H-1(a)(v)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.206(b)(5)	Out-of-Network Provider Payment	Requires out-of-network providers to coordinate with the MCP for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.	MED 1D is comparable.	If the organization approves a member to go out of network because it is unable to provide a necessary and covered service in-network, the organization coordinates payment with the out-of-network practitioner and ensures that the cost to the member is no greater than it would be if the service was furnished in-network.	Met	The MCP must require all out-of-network providers to coordinate with the MCP for payment and ensure the cost to the member is no greater than it would be if the services were furnished within network and to ensure the provider agrees with the applicable requirements. 42 CFR §438.206(b)(5) PA Appendix H-1(a)(v)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
Standard 2: Grievance System								
42 CFR 438.402 – General Requirements								
438.402 (a)	Grievance and Appeal System – General Requirements	Each MCP must have a grievance and appeal system in place for members.	RR 2A and 2B are comparable.	RR 2A: The organization has policies and procedures for registering and responding to oral and written complaints. RR 2B: The organization has policies and procedures for registering and responding to oral and written appeals.	Met	The managed care plan (MCP) must have a system in place for members that includes: a. a grievance process; and b. an appeals process. 42 CFR §438.402(a) Provider Agreement (PA) Appendix C-59	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.

NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

Table 3 (Cont.) Deeming Crosswalk for Managed Care Plans (MCPs) – 2017 Accreditation Standards

CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
438.408 (b)(3)(d)	Expedited Appeal Review Requirements	For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCP receives the appeal. This timeframe may be extended under paragraph (c) of this section.	UM 8A-9 and UM 9B-3 address resolving expedited appeals with notification to the member in 72 hours.	NA	Met	The MCP must: d. resolve the appeal as expeditiously as the member's health condition requires, but the resolution timeframe must not exceed 72 hours from the date the MCP received the appeal; 42 CFR §438.408(b)(3)(d) OAC 5160-26-08.4(E)(2)(a)-(g)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/ integrated language provisions.
Standard 3: Quality Assessment and Performance Improvement								
42 CFR 438.330 – Quality Assessment and Performance Improvement Program								
438.330(e)(2)	Program Review by the State	The State may require that an MCO, PIHP, PAHP, or PCCM entity described in §438.310(c)(2) develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program.	QI 1B is comparable.	The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service. 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices.	Met	The State may require that an MCP entity described in §438.310(c)(2) develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program. 42 CFR §438.330(e)(2)	Deemable	NCQA requirements meet all CFR provisions.

NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

Table 3 (Cont.) Deeming Crosswalk for Managed Care Plans (MCPs) – 2017 Accreditation Standards

CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
Standard 5: Coverage and Authorization of Services								
42 CFR 438.210 – Coverage and Authorization of Services								
438.210(b)(1)	Authorization of Services	For the processing of requests for initial and continuing authorizations of services, each contract must require that the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.	UM 1A-D, UM 2A-C, UM 3A, UM 4A-G, and UM 11A-E are comparable.	Multiple UM standard sections	Met	The MCP must: a. process requests for initial and continuing authorizations of services from its providers and members; b. have written policies and procedures to process requests; c. make policies and procedures available for review by ODM upon request; and d. make written policies and procedures for initial and continuing authorizations of services available to contracting and non-contracting providers upon request. 42 CFR §438.210(b)(1) OAC 5160-26-03.1(3)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.210(b)(2)(i)-(ii)	Application of Review Criteria	That the MCO, PIHP, or PAHP (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. (ii) Consult with the requesting provider for medical services when appropriate.	UM 2C language is comparable for consistent application of review criteria. UM 7A and 7D are comparable for consulting the requesting provider.	At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. 2. Acts on opportunities to improve consistency, if applicable. The organization gives practitioners the opportunity to discuss non-behavioral healthcare UM denial decisions with a physician or other appropriate reviewer.	Met	The MCP must ensure and document the following occurs when processing requests for initial and continuing authorizations of services: a. consistent application of review criteria for authorization decisions; and b. consultation with the requesting provider, when necessary. 42 CFR §438.210(b)(2)(i)-(ii) OAC 5160-26-03.1(3)(a)-(b)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.

NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

Table 3 (Cont.) Deeming Crosswalk for Managed Care Plans (MCPs) – 2017 Accreditation Standards

CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
Standard 5: Coverage and Authorization of Services								
42 CFR 438.210 – Coverage and Authorization of Services								
438.210(c)	Notice of Adverse Benefit Determination	Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the member written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the member's notice must meet the requirements of §438.404.	UM 7B and 7E address notice to the member and provider but indicate notice to both member and provider can be electronic.	NA	Met	The MCP must notify the requesting provider and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. 42 CFR §438.210(c) OAC 5160-26-03.1(3)(d)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions
438.210(e)	Compensation for Utilization Management Activities	Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §§438.3(i), and 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	UM 4G is comparable.	The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following: 1. UM decision making is based only on appropriateness of care and service and existence of coverage. 2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.	Partially Met	The MCP must ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.

NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

Table 3 (Cont.) Deeming Crosswalk for Managed Care Plans (MCPs) – 2017 Accreditation Standards

CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
Standard 5: Coverage and Authorization of Services								
42 CFR 438.114 – Emergency and Post-Stabilization Services								
438.114(d)(2)	Emergency Medical Condition Screening and Treatment	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	MED 3A is comparable.	The organization's emergency services policies and procedures require coverage of emergency services in the following situations: 1. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.	Met	The MCP must not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. 42 CFR §438.114(d)(2) OAC 5160-26-03(e)(9) PA Appendix H-3(a)(iii)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.

NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

Table 3 (Cont.) Deeming Crosswalk for Managed Care Plans (MCPs) – 2017 Accreditation Standards

CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
Standard 7: Member Information								
42 CFR 438.10 – Information Requirements								
438.10(c)(7)	Member Assistance	Each MCO, PIHP, PAHP, and PCCM entity must have in place mechanisms to help members and potential members understand the requirements and benefits of the plan.	RR 3A addresses written information provided to members about requirements and benefits of the plan. RR 4A addresses accurate information being provided to potential members.	RR 3A: The organization distributes the following written information to its subscribers upon enrollment and annually thereafter: 1. Benefits and services included in, and excluded from, coverage. 2. Pharmaceutical management procedures, if they exist. 3. Copayments and other charges for which members are responsible. 4. Benefit restrictions that apply to services obtained outside the organization's system or service area. 5. How to obtain language assistance. 6. How to submit a claim for covered services, if applicable. 7. How to obtain information about practitioners who participate in the organization. 8. How to obtain primary care services, including points of access. 9. How to obtain specialty care and behavioral healthcare services and hospital services. 10. How to obtain care after normal business hours. 11. How to obtain emergency care, including the organization's policy on when to directly access	Met	The MCP must have in place mechanisms to help members and potential members understand the requirements and benefits of the plan. 42 CFR §438.10(c)(7)	Deemable	NCQA requirements meet all CFR language provisions.

NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
				<p>emergency care or use 911 services.</p> <p>12. How to obtain care and coverage when subscribers are out of the organization's service area.</p> <p>13. How to submit a complaint.</p> <p>14. How to appeal a decision that adversely affects coverage, benefits or a subscriber's relationship with the organization.</p> <p>15. How the organization evaluates new technology for inclusion as a covered benefit.</p> <p>RR 4A: All organizational materials and presentations accurately describe the following information:</p> <ol style="list-style-type: none"> 1. Covered benefits. 2. Noncovered benefits. 3. Practitioner and provider availability. 4. Key UM procedures the organization uses. 5. Potential network, service or benefit restrictions. 6. Pharmaceutical management procedures 				
438.10(g)(1)	Member Handbook	Each MCO, PIHP, PAHP and PCCM entity must provide each member a member handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).	RR 3A addresses distribution of information in the member handbook to each member upon enrollment and annually thereafter.	The organization distributes the following written information to its subscribers upon enrollment and annually thereafter: <ol style="list-style-type: none"> 1. Benefits and services included in, and excluded from, coverage. 2. Pharmaceutical management procedures, if they exist. 3. Copayments and other charges for which members are responsible. 	Met	The MCP must provide each member a member handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a). 42 CFR §438.10(g)(1) OAC 5160-26-08.3(B)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.

NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

				<p>4. Benefit restrictions that apply to services obtained outside the organization's system or service area.</p> <p>5. How to obtain language assistance.</p> <p>6. How to submit a claim for covered services, if applicable.</p> <p>7. How to obtain information about practitioners who participate in the organization.</p> <p>8. How to obtain primary care services, including points of access.</p> <p>9. How to obtain specialty care and behavioral healthcare services and hospital services.</p> <p>10. How to obtain care after normal business hours.</p> <p>11. How to obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services.</p> <p>12. How to obtain care and coverage when subscribers are out of the organization's service area.</p> <p>13. How to submit a complaint.</p> <p>14. How to appeal a decision that adversely affects coverage, benefits or a subscriber's relationship with the organization.</p> <p>15. How the organization evaluates new technology for inclusion as a covered benefit.</p>				
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NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

Table 3 (Cont.) Deeming Crosswalk for Managed Care Plans (MCPs) – 2017 Accreditation Standards

CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
Standard 9: Credentialing								
42 CFR 438.214 – Provider Selection								
438.214(b)(2)	Provider Selection Process	Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of network providers.	CR 1A is comparable.	The organization specifies: 1. the types of practitioners it credentials and recredentials; 2. the verification sources it uses. 3. The criteria for credentialing and recredentialing; 4. the process for making credentialing and recredentialing decisions; 5. the process for managing credentialing files that meet the organization's established criteria; 6. the process for delegating credentialing or recredentialing; 7. the process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner; 8. the process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization; 9. the process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision;	Met	The MCP must follow a documented process for credentialing and recredentialing of network providers. When credentialing or recredentialing providers in connection with policies, contracts, and agreements providing basic healthcare services, the MCP must use the standardized credentialing form and process as prescribed by the Ohio Department of Insurance under sections 3963.05 and 3963.06 of the Revised Code. 42 CFR §438.214(b)(2) OAC 5160-26-05(e)(4) PA Appendix H-3(b)	Deemable	NCQA requirements include all CFR language provisions.

NCQA Standards/Elements Comparison to Code of Federal Regulations (CFR), Ohio Administrative Code (OAC), and Provider Agreement (PA) Provisions

				<p>10. the medical director or other designated physician's direct responsibility and participation in the credentialing program;</p> <p>11. the process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law; and</p> <p>12. the process for ensuring listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.</p>				
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Table 4. Element Status

Element Category	Number of Elements
Total elements eligible for deeming	115
Elements deemable	15
Elements not deemable	100



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Explanatory Notes

1. The foundation of the deeming crosswalk is the group of *Code of Federal Regulations* (CFR) provisions required by 42 CFR §438.358 (Subpart D and 42 CFR §438.330) effective 1/1/19. Each provision is grouped into a standard that includes provisions similar in nature/content. In addition, review of compliance with the following additional CFR provisions is included:
 - a. Subpart A – Member Information
 - b. Subpart B – State Responsibilities (Disenrollment)
 - c. Subpart C – Member Rights and Protections
2. In addition to CFR provisions, review of compliance with *Ohio Administrative Code* (OAC) and Provider Agreement (PA) provisions relevant to the CFR standards is incorporated.
3. Qsource deeming determination terms:
 - d. Deemable – The National Committee for Quality Assurance (NCQA) addresses all CFR, OAC, and PA criteria.
 - e. Not Deemable – NCQA does not address all CFR, OAC, and PA criteria.
 - c. NA – Not applicable
4. **Table 1** includes a comprehensive list of the CFR provisions by standard to be reviewed for deeming.

Table 1. Code of Federal Regulations (CFR) Provisions by Standard

Standard	Standard Name	CFR Subpart	CFR Citation	CFR Title
1	Access and Availability of Services	Subpart D – MCO, PIHP, and PAHP Standards	438.206	Availability of services
		Subpart D – MCO, PIHP, and PAHP Standards	438.207	Assurances of adequate capacity and services
2	Grievance System – Subpart D refers the reader to provisions in Subpart F	Subpart F - Grievance and Appeal System	438.402	General requirements
		Subpart F - Grievance and Appeal System	438.404	Timely and adequate notice of adverse benefit determination
		Subpart F - Grievance and Appeal System	438.406	Handling of grievances and appeals
		Subpart F - Grievance and Appeal System	438.408	Resolution and notification: Grievances and appeals
		Subpart F - Grievance and Appeal System	438.410	Expedited resolution of appeals



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Table 1. Code of Federal Regulations (CFR) Provisions by Standard				
Standard	Standard Name	CFR Subpart	CFR Citation	CFR Title
		Subpart F - Grievance and Appeal System	438.414	Information about the grievance and appeal system to providers and subcontractors
		Subpart F - Grievance and Appeal System	438.416	Recordkeeping and reporting requirements
		Subpart F - Grievance and Appeal System	438.420	Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending
		Subpart F - Grievance Appeal System	438.424	Effectuation of reversed appeal resolutions
3	Quality Assessment and Performance Improvement	Subpart E - Quality Measurement and Improvement: External Quality Review	438.330	Quality assessment and performance improvement program
		Subpart D - MCO, PIHP, and PAHP Standards	438.236	Practice guidelines
		Subpart D - MCO, PIHP, and PAHP Standards	438.242	Health information systems
4	Coordination and Continuity of Care	Subpart D - MCO, PIHP, and PAHP Standards	438.208	Coordination and continuity of care
5	Coverage and Authorization of Services	Subpart D - MCO, PIHP, and PAHP Standards	438.210	Coverage and authorization of services
		Subpart C - Member Rights and Protections	438.114	Emergency and post-stabilization services
6	Subcontractual Relationships and Delegation	Subpart D - MCO, PIHP, and PAHP Standards	438.230	Subcontractual relationships and delegation
7	Member Information	Subpart A - General Provisions	438.10	Information requirements
8	Member Rights and Protections	Subpart C - Member Rights and Protections	438.100	Member rights
		Subpart C - Member Rights and Protections	438.102	Provider–member communication
		Subpart C - Member Rights and Protections	438.104	Marketing activities



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Table 1. Code of Federal Regulations (CFR) Provisions by Standard				
Standard	Standard Name	CFR Subpart	CFR Citation	CFR Title
		Subpart C - Member Rights and Protections	438.106	Liability for payment
		Subpart C - Member Rights and Protections	438.108	Cost sharing
		Subpart D - MCO, PIHP, and PAHP Standards	438.224	Confidentiality
9	Credentialing	Subpart D – MCO, PIHP, and PAHP Standards	438.206(b)(6)	Availability of services
		Subpart D – MCO, PIHP, and PAHP Standards	438.214	Provider selection
10	Disenrollment	Subpart B – State Responsibilities	438.56	Disenrollment: Requirements and limitations

5. NCQA accreditation cycles for Ohio’s Medicaid managed care plans (MCPs) are included in [Table 2](#).

Table 2. Managed Care Plan (MCP) Accreditation Cycles				
Contracted Managed Care Plan	Program/Product Line	Submission	Accreditation Effective	Standards Year
Aetna	Medicare / HMO	12-05-17	02-13-18	2017
Molina Healthcare of Ohio, Inc.	Medicaid / HMO	12-01-17	02-01-18	2017
UnitedHealthcare Community Plan of Ohio, Inc.	Medicaid / HMO	10-17-17	12-29-17	2017
Buckeye Health Plan	Medicaid / HMO	01-03-19	03-18-19	2018
CareSource	Medicaid / HMO	06-19-18	10-01-18	2017
Paramount	Medicaid / HMO	01-09-18	04-17-18	2017



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6. **Table 3** includes the deeming crosswalk between CFR provisions—combined with related OAC and/or PA provisions—and any applicable NCQA standard/element.

Table 3. Deeming Crosswalk for Managed Care Plans (MCPs) – 2018 Accreditation Standards								
CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
Standard 1: Access and Availability of Services								
42 CFR 438.206 – Access and Availability of Services								
438.206(b)(2)	Direct Access to Women's Health Specialist	Provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	MED 1A is comparable.	The organization allows women direct access to in-network women's health specialists for covered routine and preventive health care services.	Met	The MCP must permit members to self-refer to any women's health specialist within the MCP's panel for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist 42 CFR §438.206(b)(2) OAC 5160-26-03(H)(4) PA Appendix H-4(c)(ii)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.206(b)(3)	Second Opinion	Provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.	MED 1C is comparable.	The organization provides for a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. NCQA explanation includes that the second opinion must be available at no more cost to the member than if the	Met	The MCP must provide for a second opinion from a qualified healthcare professional within the network or arrange for the member to obtain one outside the network, at no cost to the member. 42 CFR §438.206(b)(3) OAC 5160-26-03(D)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.



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CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
438.206(b)(4)	Out-of-Network Services	If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCP must adequately and timely cover these services out of network for the member, for as long as the MCP provider network is unable to provide them.	MED 1D is comparable.	If the organization is unable to provide a necessary and covered service to a member in-network, the organization must adequately and timely cover these services out of network for as long as the organization is unable to provide them.	Met	If the network is unable to provide necessary and covered services, the MCP must adequately and timely cover these services for the member outside of the network for as long as the MCP network is unable to provide the covered services. 42 CFR §438.206(b)(4) OAC 5160-26-03(A)(5) PA Appendix H-1(a)(v)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.206(b)(5)	Out-of-Network Provider Payment	Requires out-of-network providers to coordinate with the MCP for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.	MED 1E is comparable.	If the organization approves a member to go out of network because it is unable to provide a necessary and covered service in-network, the organization coordinates payment with the out-of-network practitioner and ensures that the cost to the member is no greater than it would be if the service was furnished in-network.	Met	The MCP must require all out-of-network providers to coordinate with the MCP for payment and ensure the cost to the member is no greater than it would be if the services were furnished within network and to ensure the provider agrees with the applicable requirements. 42 CFR §438.206(b)(5) PA Appendix H-1(a)(v)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.206(c)(3)	Furnishing Services – Accessibility Requirements	Each MCO, PIHP, and PAHP must ensure that network providers provide physical access,	MED 3A is comparable.	NA	Met	Ensure that network providers provide physical access, reasonable	Deemable	The integrated language includes references to distance, travel



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		reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.				accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) PA Appendix H-1(a)(iv)42		time, and means of transportation. NCQA requirements include these provisions.
Standard 2: Grievance System								
42 CFR 438.402 – General Requirements								
438.402(a)	Grievance and Appeal System – General Requirements	Each MCP must have a grievance and appeal system in place for members.	RR 2A, 2B, and MED 10A are comparable.	RR 2A: The organization has policies and procedures for registering and responding to oral and written complaints. RR 2B: The organization has policies and procedures for registering and responding to oral and written appeals. RR10 A: The organization's written policies and procedures specify that:...	Met	The managed care plan (MCP) must have a system in place for members that includes: a. a grievance process; and b. an appeals process. 42 CFR §438.402(a) Provider Agreement (PA) Appendix C-59	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.402(c)(1)(i)	Authority to File – Member	A member may file a grievance and request an appeal with the MCO, PIHP, or PAHP. A member may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld.	MED 10A is comparable.	NA	Met	A member may file a grievance and request an appeal with the MCP, and request a State fair hearing after receiving notice under 42 CFR 438.408 that the adverse benefit determination is upheld. 42 CFR	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.



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						§438.402(c)(1)(i) OAC 5160-26-08.4(C)(5)		
438.402(c)(2)(i)	Timing to File – Member Grievance	A member may file a grievance with the MCO, PIHP, or PAHP at any time.	MED 10 A is comparable.	NA	Met	A member may: a. file a grievance at any time; 42 CFR §438.402(c)(2)(i) OAC 5160-26-08.4(D)(1)	Deemable	The CFR language and integrated language are similar, but NCQA requirements do not meet all CFR/integrated language provisions, as described in column 4.
CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
438.402(c)(3)(i)	Procedures to File Grievance and Appeal	The member may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCP.	RR 2A and 2B address written or oral filing of grievances and appeals.	NA	Met	The member may: a. file a grievance either orally or in writing with the MCP; 42 CFR §438.402(c)(3)(i) OAC 5160-26-08.4(D)(1)(a)	Deemable	The CFR and integrated language are similar, but NCQA requirements do not meet all CFR/integrated language provisions, as described in column 4.
42 CFR 438.408 – Resolution and Notification: Grievances and Appeals								
438.408(b)(3)(d)	Expedited Appeal Review Requirements	For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCP receives the appeal. This timeframe may be extended under paragraph (c) of this section.	UM 8A-9 and UM 9B-3 address resolving expedited appeals with notification to the member in 72 hours	NA	Met	The MCP must: d.resolve the appeal as expeditiously as the member's health condition requires, but the resolution timeframe must not exceed 72 hours from the date the MCP received the appeal	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.



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CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
438.408(c)(2)(i)-(iii)	Requirements Following Extension	<p>If the MCO, PIHP, or PAHP extends the timeframes not at the request of the member, it must complete all of the following:</p> <p>(i) Make reasonable efforts to give the member prompt oral notice of the delay.</p> <p>(ii) Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.</p> <p>(iii) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.</p>	MED 10A is comparable.	<p>Although there are allowable extensions for initial UM decisions, the organization may extend the time frame by up to 14 calendar days after receipt of the appeal request, to obtain additional information when the member agrees to extend the appeal time frame.</p> <p>If the organization extends the decision time frames, it:</p> <ol style="list-style-type: none"> 1. makes a reasonable effort to give the member prompt oral notification of the delay; 2. gives the member written notice of the reason for the decision to extend the time frame, within two calendar days; 3. informs the member of their right to file a grievance if they disagree with the decision; and 	Met	<p>42 CFR §438.408(b)(3)(d) OAC 5160-26-08.4(E)(2)(a)-(g)</p> <p>If the MCP extends the timeframe for appeal not at the request of the member, the MCP must:</p> <ol style="list-style-type: none"> a. make reasonable efforts to give the member prompt oral notice of the delay; c. within two calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees; and d. resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. <p>42 CFR §438.408(c)(2)(i)-(iii) OAC 5160-26-08.4(F)(2)(c)</p>	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.



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				4. resolves the appeal as expeditiously as the member's condition requires and no later than the date when the extension expires.				
438.402(c)(1)(i)(A), §438.408(c)(3)	Deemed Exhaustion of Appeals Process	In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The member may initiate a State fair hearing.	MED 10A is comparable.	If the organization fails to meet the notice and timing requirements for grievances and appeals, the member is considered to have exhausted the organization's appeals process and may initiate a State Fair Hearing.	Met	If the MCP fails to adhere to the notice and timing requirements for an appeal, the member is deemed to have exhausted the MCP's appeal process and may initiate a State fair hearing. 42 CFR §438.402(c)(1)(i)(A), §438.408(c)(3) OAC 5160-26-08.4(G)(1)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.408(d)(2) (i)-(ii)	Format of Notice – Appeals	For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10. (ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.	MED 10A and MED 12F are comparable	The organization uses language that is easy to understand and readily accessible to members in accordance with state and federal requirements, including, but not limited to language services and auxiliary aids or assistance, upon member request. Oral grievance. Grievances filed orally, may be responded to	Met	For all appeals, the MCP must provide written notice of resolution in a format and language that, at minimum, meets standards described in 42 CFR 438.10. For notice of an expedited resolution, the MCP must make reasonable efforts to provide oral notice. 42 CFR §438.408(d)(2)(i)-(ii) OAC 5160-26-08.4	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.



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CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
42 CFR 438.414 – Information about the Grievance and Appeal System to Providers and Subcontractors								
438.414	Grievance and Appeal Provider and Subcontractor Information	The MCO, PIHP, or PAHP must provide information specified in §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.	MED 10B is comparable.		Met	The MCP must provide its grievance, appeal, and State fair hearing procedures and timeframes to its contracting providers, including: a. the member's right to file grievances and appeals and the requirements and timeframes for filing; b. the member's right to a State fair hearing, the requirements and timeframes for	Deemable	NCQA language does address provisions (a), (c), (d) of the integrated language.



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CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
42 CFR 438.416 – Recordkeeping Requirements								
42 CFR §438.416(a)-(b)(1)-(6)	Recordkeeping Requirements	The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. (b) The record of each grievance or appeal must contain, at a minimum, all of the following information: (1) A general description of the reason for the appeal or grievance. (2) The date received. (3) The date of each review or, if applicable, review meeting.	MED 10C does not address the resolution at each level of the grievance or appeal.	NA	Met	The MCP must maintain and review records of grievances and appeals that contain the following information: a. a general description of the reason for the appeal or grievance; e. the date received; f. the date of each review or, if applicable, review meeting; g. resolution at each level of the appeal or grievance, if applicable; h. date of resolution at each level, if applicable; and	Deemable	The CFR language and integrated language are similar, and NCQA requirements do not meet all CFR/integrated language provisions, as described in column 4.



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42 CFR 438.420 – Continuation of Benefits while the MCO, PIHP, or PAHP Appeal and the State Fair Hearing Are Pending								
438.420(c)(1)-(3)	Continuation of Benefits – Duration	<p>(4) Resolution at each level of the appeal or grievance, if applicable. (5) Date of resolution at each level, if applicable. (6) Name of the covered person for whom the appeal or grievance was filed.</p> <p>If, at the member's request, the MCO, PIHP, or PAHP continues or reinstates the member's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs: (1) The member withdraws the appeal or request for state fair hearing. (2) The member fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the member's appeal under §438.408(d)(2). (3) A State fair hearing office issues a hearing decision adverse to the member.</p>	MED 11C is comparable.	he organization's policies and procedures specify that it provides continued coverage until one of the following occurs: 1. The member withdraws the appeal or request for a State Fair Hearing. 2. The member fails to request a State Fair Hearing and continued coverage within 10 calendar days. 3. A State Fair Hearing issues a denial or upheld appeal.	Met	<p>i. name of the covered person for whom the appeal or grievance was filed. 42 CFR §438.416(a)-(b)(1)-(6) PA Appendix C-59(b)</p> <p>If the MCP reinstates the member's benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of following occurs: a. the member withdraws the appeal or request for the State fair hearing; the member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the MCP sends the notice of an adverse resolution to the member's appeal under 42 CFR 438.408(d)(2); or k. a State fair hearing office issues a hearing decision adverse to the member.</p>	Deemable	The CFR language and integrated language are similar, but NCQA requirements do not address CFR/ integrated language provisions.



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42 CFR §438.420(c)(1)-(3) OAC 5160-26-08.4(H)(2)(a)-(c)								
42 CFR 438.424 – Effectuation of Reversed Appeal Resolutions								
438.424(a)	Effectuation of Reversed Appeal Resolutions – Services Not Furnished while the Appeal Is Pending	If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	MED 10D is comparable.	The organization takes the following steps after an overturned internal or external appeal: 1. The organization provides or authorizes services within 72 hours of an overturned appeal, if services were not provided pending the outcome of the appeal. 2. The organization provides compensation for services provided while an appeal decision was pending.	Met	If the MCP or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCP must authorize or provide the disputed services as expeditiously as the member’s health condition requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.424(a) OAC 5160-26-08.4(G)(8)(a)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.424(b)	Effectuation of Reversed Appeal Resolutions – Services Furnished while the Appeal Is Pending	If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO, PIHP, or PAHP, or the State must pay for those services, in accordance with State policy and regulations.	MED 10D is comparable.	The organization takes the following steps after an overturned internal or external appeal: 1. The organization provides or authorizes services within 72 hours of an overturned appeal, if services were not provided pending the outcome of the appeal.	Not Met	If the MCP or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCP or ODM must pay for those services, in accordance with ODM policy and regulations. 42 CFR §438.424(b)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.



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				2. The organization provides compensation for services provided while an appeal decision was pending.		OAC 5160-26-08.4(G)(8)(b)		
CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
Standard 3: Quality Assessment and Performance Improvement								
42 CFR 438.330 – Quality Assessment and Performance Improvement Program								
438.330(e)(2)	Program Review by the State	The State may require that an MCO, PIHP, PAHP, or PCCM entity described in §438.310(c)(2) develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program.	QI 1B is comparable.	The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service. 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices.	Met	The State may require that an MCP entity described in §438.310(c)(2) develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program. 42 CFR §438.330(e)(2)	Deemable	NCQA requirements meet all CFR provisions.
42 CFR 438.236 – Practice Guidelines								
438.236(b)(1)-(4)	Adoption of Practice Guidelines	Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that	MED 2A is comparable.	The organization adopts at least four evidence-based clinical practice	Met	The MCP must adopt practice guidelines that:	Deemable	The CFR language and integrated language are similar, and NCQA



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		meet the following requirements: (1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field. (2) Consider the needs of the MCO's, PIHP's, or PAHP's members. (3) Are adopted in consultation with contracting health care professionals. (4) Are reviewed and updated periodically as appropriate.		guidelines, approved by its QI committee, that: 1. Are based on valid and reliable clinical evidence or a consensus of practitioners in the particular field. 2. Consider the needs of the organization's members. 3. Are adopted in consultation with contracted health care professionals. 4. Are reviewed and updated at least every two years, as applicable.		a. are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field; b. consider the needs of the MCP's members; c. are adopted in consultation with contracting healthcare professionals; and d. are reviewed and updated periodically as appropriate. 42 CFR §438.236(b)(1)-(4) OAC 5160-26-05.1(B)(1)-(4)(1)-(4)		requirements meet all CFR/integrated language provisions.
CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
438.236(c)	Dissemination of Guidelines	Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to members and potential members.	MED 2B is comparable.	NA The organization distributes the evidence-based guidelines it adopted in MED 2, Element A, to the appropriate practitioners and to members and potential members, upon request.	Met	The MCP must disseminate the practice guidelines to: a. all affected providers; and members and potential members, upon request. 42 CFR §438.236(c) OAC 5160-26-05.1(B)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
Standard 4: Coordination and Continuity of Care								
42 CFR 438.208 – Coordination and Continuity of Care								
438.208(b)(1)	Ongoing Source of Care	Each MCO, PIHP, and PAHP must implement	MED 5A is comparable.	The organization's care coordination	Met	The managed care plan (MCP) must	Deemable	The CFR language and integrated



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		<p>procedures to deliver care to and coordinate services for all MCO, PIHP, and PAHP members. These procedures must meet State requirements and must do the following: Ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity.</p>		<p>process includes provisions for all members including: 1. Having a person or entity formally assigned to coordinate health care services provided to members. 2. Providing the contact information of the individuals coordinating healthcare services to members.</p>		<p>ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact his or her designated person or entity. 438.208(b)(1) OAC 5160-26-03.1</p>		<p>language are similar, and NCQA requirements meet all CFR/integrated language provisions.</p>
CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
438.208(b)(3)	Initial Screening	The MCP must make a best effort to conduct an initial screening of each member’s needs within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful.	MED 6A is comparable, except that it does not address subsequent contact attempts.	NA	Met	The MCP must make a best effort to conduct an initial screening of each member’s needs within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. 438.208(b)(3)	Deemable	NCQA requirements do not meet all CFR language provisions, as described in column 4
438.208(b)(4)	Assessment of Member Needs	The MCP must share with ODM or other MCPs serving the member the results of any identification and assessment of that	MED 6B is comparable.	The organization shares the results of its identification and assessment of members with:	Met	The MCP must share with the ODM or other MCPs serving the member the results of any identification and assessment of that	Deemable	NCQA requirements meet all CFR language provisions.



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CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
		member's needs to prevent duplication of those activities.		1. The state. 2. Other organizations serving the member.		member's needs to prevent duplication of those activities. 42 CFR §438.208(b)(4)		
438.208(b)(5)	Member Health Record	The MCP must ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.	MED 5B is comparable.	The organization requires: 1. Practitioners to maintain member health records, as appropriate and in accordance with professional standards. 2. Practitioners to share member health records, as appropriate and in accordance with professional standards. 3. Providers to maintain member health records, as appropriate and in accordance with professional standards. 4. Providers to share member health records, as appropriate and in accordance with professional standards.	Met	The MCP must ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5)	Deemable	NCQA requirements meet all CFR provisions.
438.208(c)(4)	Member Direct Access to Specialists	For members with special health care needs determined through an assessment (consistent with paragraph (c)(2) of this	MED 1B is comparable.	The organization allows direct access to specialists, appropriate for the condition and identified needs of:	Met	The MCP must have mechanisms in place to provide members determined to have special healthcare needs with direct	Deemable	NCQA requirements meet all CFR provisions.



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		section) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.		1. Members with special health care needs. 2. Members who need LTSS.		access to a specialist in a manner that is appropriate for the member's condition and identified needs. Direct access may include, but is not limited to, a standing referral or an approved number of visits. To prevent duplication of work, assessments related to a member's special healthcare needs and direct access determinations must be provided to ODM or another MCP. The MCP must accept such information as assessed by another MCP in the ODM program. 42 CFR §438.208(c)(4)		
Standard 5: Coverage and Authorization of Services								
42 CFR 438.210 – Coverage and Authorization of Services								
438.210(b)(1)	Authorization of Services	For the processing of requests for initial and continuing authorizations of services, each contract must require that the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.	UM 1A-D, 2A-C, 3A, 4A-G, and 11 A-E are comparable.	Multiple UM standard sections	Met	The MCP must: e. process requests for initial and continuing authorizations of services from its providers and members; f. have written policies and procedures to process requests; g. make policies and procedures available for	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.



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CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
						review by ODM upon request; and h. make written policies and procedures for initial and continuing authorizations of services available to contracting and non-contracting providers upon request. 42 CFR §438.210(b)(1) OAC 5160-26-03.1(3)		
438.210(b)(2) (i)-(ii)	Application of Review Criteria	That the MCO, PIHP, or PAHP (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. (ii) Consult with the requesting provider for medical services when appropriate.	UM 2C language is comparable for consistent application of review criteria. UM 7A and 7D are comparable for consulting the requesting provider.	At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. 2. Acts on opportunities to improve consistency, if applicable. The organization gives practitioners the opportunity to discuss non-behavioral healthcare UM denial decisions with a physician or other appropriate reviewer.	Met	The MCP must ensure and document the following occurs when processing requests for initial and continuing authorizations of services: c. consistent application of review criteria for authorization decisions; and d. consultation with the requesting provider, when necessary. 42 CFR §438.210(b)(2)(i)-(ii) OAC 5160-26-03.1(3)(a)-(b)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.210(b)(3)	Appropriate Reviewer Expertise	That any decision to deny a service authorization request or	UM 4B is comparable	NA	Met	The MCP must ensure that any decision to deny a service	Deemable	The CFR language and integrated



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		to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs.				authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the member's medical or behavioral health needs. 42 CFR §438.210(b)(3) OAC 5160-26-03.1(2)(c)-(d)		language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.210(c)	Notice of Adverse Benefit Determination	Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the member written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the member's notice must meet the requirements of §438.404.	UM 7B and UM 7E are comparable.	The organization's written notification of non-behavioral healthcare denials, provided to members and their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion	Met	The MCP must notify the requesting provider and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. 42 CFR §438.210(c) OAC 5160-26-03.1(3)(d)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.



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				on which the denial decision was based, upon request.				
438.210(e)	Compensation for Utilization Management Activities	Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §§438.3(i), and 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	UM 4G is comparable.	The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following: 1. UM decision making is based only on appropriateness of care and service and existence of coverage. 2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.	Partially Met	The MCP must ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
CFR Provision Cite	CFR Title	CFR Language	Applicable NCQA Standard/ Element Comparability	NCQA Language	NCQA Deeming Determination	Integrated Element Language (CFR, OAC, PA) and Provision Cite(s)	Qsource Deeming Determination	Comments
42 CFR 438.114 – Emergency and Post-Stabilization Services								
438.114(d)(2)	Emergency Medical Condition Screening and Treatment	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	MED 9C is comparable.	The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs. 2. The organization meets this element if its policies and procedures state	Met	The MCP must not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. 42 CFR §438.114(d)(2)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.



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				that it covers all ER and post stabilization care claims or does not deny any ER and post stabilization care claims.		OAC 5160-26-03(E)(9) PA Appendix H-3(a)(iii)		
Standard 7: Member Information								
42 CFR 438.10 – Information Requirements								
438.10(c)(7)	Member Assistance	Each MCO, PIHP, PAHP, and PCCM entity must have in place mechanisms to help members and potential members understand the requirements and benefits of the plan.	RR 3A addresses written information provided to members about requirements and benefits of the plan. RR 4A addresses accurate information being provided to potential members.	RR 3A: The organization distributes the following written information to its subscribers upon enrollment and annually thereafter: 1. Benefits and services included in, and excluded from, coverage. 2. Pharmaceutical management procedures, if they exist. 3. Copayments and other charges for which members are responsible. 4. Benefit restrictions that apply to services obtained outside the organization's system or service area. 5. How to obtain language assistance.	Met	The MCP must have in place mechanisms to help members and potential members understand the requirements and benefits of the plan. 42 CFR §438.10(c)(7)	Deemable	NCQA requirements meet all CFR language provisions.



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			<p>6. How to submit a claim for covered services, if applicable.</p> <p>7. How to obtain information about practitioners who participate in the organization.</p> <p>8. How to obtain primary care services, including points of access.</p> <p>9. How to obtain specialty care and behavioral healthcare services and hospital services.</p> <p>10. How to obtain care after normal business hours.</p> <p>11. How to obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services.</p> <p>12. How to obtain care and coverage when subscribers are out of the organization's service area.</p> <p>13. How to submit a complaint.</p> <p>14. How to appeal a decision that adversely affects coverage, benefits or a subscriber's relationship with the organization.</p> <p>15. How the organization evaluates new technology for</p>		
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				inclusion as a covered benefit. RR 4A: All organizational materials and presentations accurately describe the following information: 1. Covered benefits. 2. Noncovered benefits. 3. Practitioner and provider availability. 4. Key UM procedures the organization uses. 5. Potential network, service or benefit restrictions. 6. Pharmaceutical management procedures				
438.10(f)(1)	Provider Termination Notice	The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	MED 1H is comparable.	The organization provides written notification to affected members of a practitioner or practice group within 15 calendar days after receipt or issuance of the termination notice.	Met	The MCP must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. 42 CFR §438.10(f)(1) OAC 5160-26-05(b)(ii)	Deemable	The CFR language and integrated language are similar, and NCQA requirements meet all CFR/integrated language provisions.
438.10(g)(1)	Member Handbook	Each MCO, PIHP, PAHP and PCCM entity must	RR 3A address distribution of	RR 3A: The organization	Met	The MCP must provide each member a	Deemable	The CFR language and integrated



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		<p>provide each member a member handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).</p>	<p>information in the member handbook to each member upon enrollment and annually thereafter.</p>	<p>distributes the following written information to its subscribers upon enrollment and annually thereafter:</p> <ol style="list-style-type: none"> 1. Benefits and services included in, and excluded from, coverage. 2. Pharmaceutical management procedures, if they exist. 3. Copayments and other charges for which members are responsible. 4. Benefit restrictions that apply to services obtained outside the organization's system or service area. 5. How to obtain language assistance. 6. How to submit a claim for covered services, if applicable. 7. How to obtain information about practitioners who participate in the organization. 8. How to obtain primary care services, including points of access. 9. How to obtain specialty care and behavioral healthcare services and hospital services. 10. How to obtain care after normal business hours. 		<p>member handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a). 42 CFR §438.10(g)(1) OAC 5160-26-08.3(B)</p>		<p>language are similar, and NCQA requirements meet all CFR/integrated language provisions.</p>
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				<p>11. How to obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services.</p> <p>12. How to obtain care and coverage when subscribers are out of the organization's service area.</p> <p>13. How to submit a complaint.</p> <p>14. How to appeal a decision that adversely affects coverage, benefits or a subscriber's relationship with the organization.</p> <p>15. How the organization evaluates new technology for inclusion as a covered benefit.</p> <p>MED 8A: The organization provides the following information to members in the member handbook:</p> <p>1. Benefits provided by the state and how and where to access the benefits, including transportation.</p> <p>2. Services not covered or provided for by the organization because of moral or religious objections.</p> <p>3. How to obtain information from the state about how and</p>				
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				where to access services not covered or provided because of moral or religious objections.				
Standard 9: Credentialing								
42 CFR 438.214 – Provider Selection								
438.214(b)(2)	Provider Selection Process	Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of network providers.	CR 1A is comparable.	The organization specifies: 1. the types of practitioners it credentials and recredentials; 2. the verification sources it uses. 3. The criteria for credentialing and recredentialing; 4. the process for making credentialing and recredentialing decisions; 5. the process for managing credentialing files that meet the organization's established criteria; 6. the process for delegating credentialing or recredentialing; 7. the process for ensuring that credentialing and recredentialing are conducted in a	Met	The MCP must follow a documented process for credentialing and recredentialing of network providers. When credentialing or recredentialing providers in connection with policies, contracts, and agreements providing basic healthcare services, the MCP must use the standardized credentialing form and process as prescribed by the Ohio Department of Insurance under sections 3963.05 and 3963.06 of the Revised Code. 42 CFR §438.214(b)(2) OAC 5160-26-05(C)(4) PA Appendix H-3(b)	Deemable	NCQA requirements include all CFR language provisions.



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				<p>nondiscriminatory manner;</p> <p>8. the process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization;</p> <p>9. the process for ensuring that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision;</p> <p>10. the medical director or other designated physician's direct responsibility and participation in the credentialing program;</p> <p>11. the process for ensuring the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law; and</p> <p>12. the process for ensuring listings in practitioner</p>				
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				directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.				
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Element Category	Number of Elements
Total elements eligible for deeming	118
Elements deemable	36
Elements not deemable	82

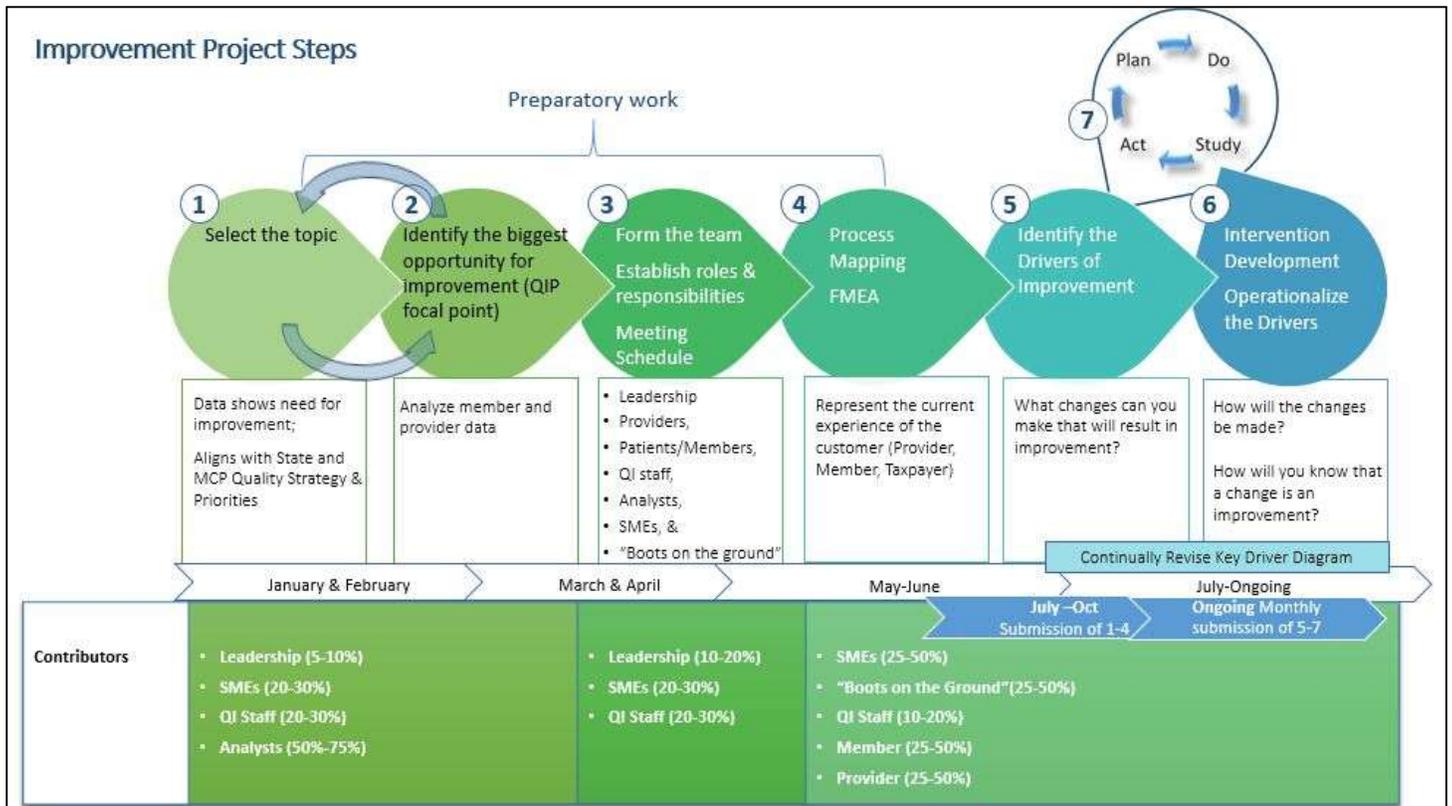
APPENDIX E—MEDICAID MANAGED CARE QI PROJECT GUIDANCE

APPENDIX E—MEDICAID MANAGED CARE QI PROJECT GUIDANCE

ODM currently requires Ohio’s Medicaid Managed Care Plans (MMCPs) to participate in both quality improvement (QIPs) and performance improvement projects (PIPs) using quality improvement science tools and methods that are based on the Associates in Process Improvement’s (API) Model for Improvement and used by the Institutes for HealthCare Improvement (IHI). While PIPs require formal validation by an external review organization, due to the similar focus on improving quality of health outcomes, no less rigor should be applied when conducting of QIPs

The following document provides guidance in developing the foundations needed for improvement projects. Resources consulted in the development of this guidance include: NCQA 2015 Standards and Guidelines for the Accreditation of Health Plans, the Managed Care Resources, Inc.’s Medical Management Signature Series, the Improvement Guide: A practical Approach to Enhancing Organizational Performance, and the National Association of County and City Health Officials’ (NACCHO) Roadmap to a Culture of Quality Improvement.

Before beginning any improvement project, there are certain foundational structures that need to be in place. These include the active involvement of leadership and adequate resources (human, IT, analytical) and a corporate culture that supports continuous improvement.



Steps one through four are active project planning and should occur prior to formally beginning the quality improvement project. All seven steps and the timeline for submission is outlined below in more detail.

1. **Select the topic.**

Before beginning an improvement project, you must know what you want to improve. This will often involve comparing your data to benchmarks, other Managed Care Plans, or to how your Plan is performing in other states. Topics should align with the strategic priorities of the Plan's and the State's Quality Strategies. Although topics will often be informed by Plan performance on specific measures (such as HEDIS), topic selection should reflect a population management approach which incorporates a life-course perspective extending beyond a single event or episode.

This activity will involve consultation with leadership to ensure alignment with priorities and to garner needed support, analysis of data to determine the greatest need for improvement, working with Subject Matter Experts (SMEs) to determine realistic and achievable goals and expectations, and input from QI staff to assist in establishing and refining stretch goals.

2. **Identify the biggest opportunity for improvement (the QIP Focal Point).**

After you've determined what to improve, you will want to target that improvement. In analyzing your member and provider data, you may find that a sub-population or geographical area has comparatively poorer outcomes. In analyzing your provider data, you may find that some providers have more patients who are not getting recommended care. When identifying provider partners, you will want to work to develop a collaborative relationship in which the provider is an active participant on your improvement team. You will want to set the stage early on for data collection and tracking in order to see the results of your improvement efforts.

When identifying the focus of the QIP, you will need to consider weekly data submissions. Will there be enough observations per week for you to see progress in your SMART Aim. When you are determining the volume that you need, you will need to consider how common the outcome is that you are seeking to change. A general rule of thumb is that each week, your weekly denominator will need to be large enough to allow you to see an outcome at least five percent of the time. The rarer your outcome, the larger your population will need to be to meaningfully track change over time.

“Begin with the End in Mind” Stephen Covey

(...and be SMART About It).

SMART Aims are Specific, Measurable, Achievable and Relevant.

In order to be SPECIFIC, you will want to ask the questions:

- **What do I want to accomplish? (By how much do I want to improve?)**
- **What are the benefits of accomplishing this goal?**
- **Who is involved? (Where will my improvement project occur? Who are the partners?)**
- **Where will the improvement be focused?**
- **What are requirements or restraints?**

In order to know whether you’ve improved, your SMART Aim will need to be MEASURABLE (i.e. Quantifiable).

- **How much?**
- **How many?**
- **How will I know when it is accomplished?**

The ACHIEVABLE part of the SMART acronym answers the question:

- **How realistic is the goal?**

Is it RELEVANT? Does the goal matter?

Making a goal TIME-BOUND involves giving it a target date so that the team can focus their efforts on completion of the goal on or before the due date.

3. Form the Team.

Effective teams include members representing three different kinds of expertise: systems leadership, technical expertise, and day-to-day leadership. There may be one or more individuals on the team with each kind of expertise, or one individual may have expertise in more than one area, but all three areas should be represented in order to drive improvement successfully.

An ideal team member has certain key characteristics, including: the ability to actively listen and maintain open communication, is committed to the project’s success and is willing to assume individual responsibility for the team’s results, enjoys problem solving and is solution oriented, is flexible and willing to grow and learn.

Leadership Involvement

Leadership should be involved throughout the project. Leadership support and guidance is essential not only for selecting the topic area, but also for assisting the team in garnering needed resources and organizational support. Team members may serve one or more of the following commonly seen leadership roles but may also provide technical expertise to the project.

Project Sponsor

A successful improvement team needs a sponsor, someone with executive authority who can liaison with other areas of the organization, serve as a link to senior management and the strategic aims of the organization, provide resources and overcome barriers on behalf of the team, and provide accountability for the team members. The Sponsor is not a day-to-day participant in team meetings and testing, but should receive weekly updates on the team's progress.

Subject Matter Leadership

Teams need someone with enough authority to test changes that are suggested and to deal with any issues that arise. The team's subject-matter leader understands both the practical implications of proposed changes and the consequences such a change might trigger in other parts of the system. For Medicaid Improvement Projects, it is helpful to have subject matter leaders both within the Managed Care Plan and within the Partner Provider site.

Quality Improvement Leadership (1 FTE minimum)

Quality Improvement Leadership understands how the improvement project supports the organizations larger improvement portfolio and also provides needed training and resources for other team members.

Day-to-Day Leadership (1 FTE minimum)

Day-to-day leaders drive the project, assuring that tests are implemented and overseeing data collection. It is important that this person understands not only the details of the system, but also the various effects of making change(s) in the system. This person also needs to be able to work effectively with the physician champion(s).

Day-to-day leaders should be heavily involved in the project and attend all meetings and huddles. Organizational leaders and project sponsors are generally involved more frequently at the beginning of a project. However, while organizational leaders and project sponsors may not be involved in every meeting, they should receive weekly summaries outlining project progress and lessons learned. These succinct, weekly summaries should be open and honest in order to quickly garner any additional support and resources.

Technical Expertise

In addition to the often-recognized technical fields of statistical analysis, improvement science, and IT, technical experts include subject matter experts who understand service delivery, and internal processes and procedures. With Medicaid Improvement Projects, technical expertise generally resides in both the MCP and the Provider Partner Site due to the importance of both Plan and Provider site in providing quality healthcare.

Improvement Science Expertise (recommended 1 FTE minimum)

At least one individual with quality improvement expertise should be involved in all steps of the quality improvement project. This team member is important for a number of reasons. An expert in quality improvement science can assist the team in using tools like process mapping, Pareto Charts and Failure Mode and Effects Analysis to determine key drivers and their relative impact. Quality Improvement experts can also provide technical support by helping the team determine what to measure, assisting in design of simple, effective measurement tools, and providing guidance on collection, interpretation, and display of data. At a minimum, quality improvement staff should attend the weekly team meetings and meet regularly with project analysts. It may also be advisable to periodically have them participate in provider huddles.

Analysts (recommended 1 FTE minimum)

Your analysts are key in helping you determine what to measure, how to collect and store the data, ensuring data quality and integrity, and analyzing data over time so that you can readily see whether the changes to your processes (interventions) have had the intended impact. Depending on the volume and complexity of your data and project, assigning a senior and junior level analyst to work as a team may be beneficial.

Data Entry (recommended 1 FTE minimum)

Data entry personnel are key to timely use of data to inform progress on process and outcome measures as well as the results of tests of change. Data entry personnel should have an understanding of the rationale for data collection and how their work contributes to the project outcomes and goals. They should also work closely with data analysts to ensure data quality. The number of hours that will need to be devoted to data entry will be influenced by both the volume and complexity of your project and data.

Subject Matter Experts (recommended 1 FTE minimum)

Subject matter experts should be involved in every step of the improvement process outlined in Figure 1. This includes attending weekly internal meetings and may also include attending provider huddles.

“Boots on the Ground” or “Line staff” (depends on the project)

In addition to these leadership roles, you will want the direct involvement of the individuals conducting the actual work, your “boots on the ground” and your members or patients. Those doing the actual work will have lots to contribute in helping you understand the current process and generating ideas for improvement (drivers). The

number of full-time equivalent employees that will be needed to do the day-to-day improvement work with members and providers will vary depending on the project, but will rarely be less than two.

“Member Perspective” (One or more)

These are the people we serve every day and whose health and well-being we seek to improve. Listening to their voice regarding what the system “feels” like can give you valuable insight into areas for improvement that may not be readily identifiable from the Plan or Provider perspective. Your provider partner, member services, or care management team may be able to help you identify patients who will be impacted by your improvement project. Identifying, engaging and retaining the involvement of members is often the most challenging piece of your team building and maintenance, but provides substantial rewards in helping you focus on what truly matters. Obtain member input any way you can and involve them at all possible points.

“Provider Perspective”

It is imperative that members of your team receive at least basic training in quality improvement science tools and methods and understand the time commitment required for quality improvement work. Setting expectations upfront will help mitigate future frustration and confusion. As you pull together your team, you will also want to begin scheduling regular quality improvement meetings to discuss issues, review results, and strategize.

4. Map the Current Process

You need to understand your current process in order to know where it is not working as intended. Often we focus on how a system is intended to work rather than what is actually taking place. Talking to the members of your team, particularly those on the front lines, will allow you to achieve a deeper understanding of how a process is being carried out in practice. It is possible that the process is not broken, but is not being implemented as intended. Identifying what is actually happening will help determine whether you need to make adhering to the process easier or whether revisions are needed.

An additional benefit of mapping out the current process with your team is that completion of this exercise has you to have a shared understanding of how things are currently working (or not). The next step is to think about what you might need to change, better define or invent.

Although it may have been painful to discover how different your current process looks from your ideal state, the exercise above is crucial for helping you determine where you can improve. You may find places where there was no process (or no clear process in place) and one needs to be developed. You also may find places where the current process is failing and identify ways of mitigating those failures. That’s one way in which your drivers of improvement are identified.

The next steps, identifying drivers, developing interventions, and testing those interventions, are inter-related in that the testing of the interventions, provides insight on whether the

intervention is effective and may also help determine whether the driver is as important as the team originally thought.

5. Identifying Drivers.

Drivers toward your SMART Aim can be identified multiple ways. Some common methods of identifying drivers include: in-depth interviews with providers regarding what is and what is not working; through member focus groups or surveys; literature reviews; discussions with other Plans; and by creatively coming up with solutions to address identified barriers or failures. The drivers of your SMART Aim illustrate your theory of what you think will lead to improvement. Having the whole team contribute to at least the cursory brain-storming will allow you to identify many potential drivers upfront. You will find that these will be revisited as you learn more about the topic, work more closely with your partners, and test, test, and test some more. The next step is operationalizing these into interventions that you can test.

6. Developing & 7. Testing Interventions.

Where drivers are the “what”; interventions are the “how”. You’ve identified what you think will impact your SMART Aim; now you need to figure out how you will test whether your hypothesized drivers will lead to the improvement you want. The interventions are what you test through your PDSA cycles. The result of the PDSA cycle determines whether you want to continue testing the same intervention on a different scale or in different circumstances (adopt), whether you want to change your intervention (or how it was implemented) slightly (adapt), or remove the intervention from your key driver diagram all together (abandon).

Submissions to ODM at each phase of the process

Unlike PIPs, QIPs do not require a formal evaluation by an External Quality Review Organization. However, the level of commitment to improvement must be similar and formal quality improvement tools should still be used to help you determine your project focus, understand your processes, track your progress, and document your success. Submission of these tools will be used by ODM to provide you with needed technical assistance to move your project further faster.

The six months prior to beginning a QIP should be a time of data analysis and planning. The work done during this time period should inform the first four submissions to ODM. The timeline for QIP submissions due during the state fiscal year is below:

Date Due to ODM	Submission	Submission Topic
July 1 st (based on pre-work)	Submission 1:	Topic Selection & Associated Data Analysis QIP Focal Point & Associated Analysis <i>(These should be based on your six months of pre-work)</i>

APPENDIX E—MEDICAID MANAGED CARE QI PROJECT GUIDANCE

<p>August 1st</p>	<p>Submission 2:</p>	<p>QIP Team Members For each member, provide:</p> <ol style="list-style-type: none"> 1. Rationale for inclusion on team; 2. QI experience & training; 3. Role in organization 4. Role on team (analyst, sponsor, technical expert, QI lead, member, provider partner, etc.)
<p>September 1st</p>	<p>Submission 3:</p>	<p>Detailed Current State Process Map The process map should reflect the perspective of the person for whom you are improving outcomes and should include areas where the process is unclear.</p>
<p>October 1st</p>	<p>Submission 4:</p>	<p>Simplified Failure Mode and Effects Analysis (FMEA) & initial KDD In addition to the simplified FMEA and initial KDD, this submission should include a narrative which discusses:</p> <ol style="list-style-type: none"> 1. Rationale for selection of drivers (interviews, literature reviews, etc.) 2. Rationale for interventions (Pareto charts, best practices, root cause analysis, etc.) 3. Description of how the intervention is linked to the driver

<p>November 15th –June 15th</p>	<p>Monthly submissions (5-8) of PDSAs, revised KDDs, and run charts</p>	<p>Monthly submissions of PDSAs, revised KDDs and run charts For PDSAs, include the following:</p> <ol style="list-style-type: none"> 1. The intervention that is being tested & the driver it impacts 2. The objective of the test 3. A brief description of the test 4. Your prediction of what will happen 5. The tasks necessary to complete the test, the person responsible for each task, when the task is occurring, and where the task is occurring 6. Whether the test was carried out as planned 7. What you observed and whether the observations were or were not part of your plan 8. Whether your results matched your predictions 9. How your results compared to your previous performance 10. What you learned from comparing the test to your predictions and previous performance 11. Whether as a result of the test you will be: <ol style="list-style-type: none"> a. Improving the change and continuing your testing plan & if so what your plans or changes are for the next test (adapt) b. Whether you will be testing changes on a larger scale and developing an implementation plan and plan for sustainability (adopt) c. Whether you plan to discard this change idea and try a different one (abandon) <p>Remember: Project success is driven by testing; the more PDSA cycles completed, the more rapidly you will move toward your desired outcome.</p> <p>Each revised KDD should reflect the PDSA results</p> <p>Each run chart should reflect weekly data collected during that month.</p>
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More detail about each submission is provided below. Submission templates follow at the end of the document.

Submission 1: Topic Selection & QIP Focal Point.

This submission should include the topic of the QIP and where your Plan will be focusing its efforts. Both of these sections should include the analytical or other rationale for these choices. For topics selected due to not meeting pay-for-performance thresholds, the Plan should state that the topic was chosen for that reason, but then include the methods and analyses for determining which aspects of the

topic will be focused on, a brief description (one to two paragraphs) as to why the particular aspect was chosen, and what methods and analytical results the Plan used to determine where its focus should lie (examples of focal points might include a geographical region, poor performing providers, or a subpopulation of members).

Submission 2: QIP Team Members

This submission should not only include the names of your Team Members, but should also include:

1. The rationale for inclusion on the team. The explanation should answer questions such as:
 - a. What does this member contribute to the team?
 - b. How does she or he inform the team's decisions?
 - c. What is this member's influence within the larger organization?
 - d. What decision-making authority does this team member have?
 - e. What does the team member know about the subject matter?
 - f. What type and level of expertise will the team member contribute?
2. The team member's QI experience & training (training in methods and tools, practical application, etc.)
3. Their role on the team (analyst, technical expert, Plan member, provider partner, executive sponsor, QI lead/coach) and their role within the organization.

It is expected that as your QIP develops, you may need to revisit your team make-up. Please incorporate additional partners as needed.

Submission 3. Detailed **Current State Process Map** from the perspective of the person for whom you are improving outcomes. The Process Map should be constructed with input from the actual people involved in the process. It is important to create a safe environment during this step so that your team members and other staff feel empowered to talk about how things are actually occurring in practice even if this does not align with corporately prescribed procedures.

Submission 4. Simplified Failure Mode and Effects Analysis (FMEA) & initial KDD

The simplified Failure Mode and Effects Analysis is built from the sub-processes of your more detailed process map. For each sub-process map, you will determine what the barriers are to successful completion of each step and what might be done (interventions) to mitigate those barriers. Your whole team and those involved in the actual processes should contribute to the brainstorming involved in identifying barriers (failure modes) and interventions. The interventions identified during this exercise, along with interviews with staff, your provider champions, and members; and literature reviews to identify best practices will then help you complete the key driver diagram.

This submission also includes a narrative in which you will describe the rationale for choosing the drivers of improvement for your topic, including the methods and analyses used to identify them, how your interventions are tied to your drivers, and your initial plans for testing. A Pareto chart is often useful at this stage in that it allows you to clearly see the impact of each of your drivers. When used with your FMEA analysis, the Pareto chart helps you better target your resources towards interventions that will

have the largest impact. If data on barriers to your outcome (failures) is not readily available to complete a Pareto chart, capitalize on the subject matter, provider, and member expertise within your team.

Ongoing Monthly submissions of PDSAs, revised KDDs and Run Charts

Your Plan's QIP team should have frequent ongoing check-ins. These allow the team to respond to the results of testing, plan for next steps, and keep the theory of change (KDD) up to date. Weekly check-ins with your provider partner will ensure that the collaborative relationship stays strong. Weekly data should be used to map progress over time.

On a monthly basis, you will fill out a table listing the PDSAs you completed and submit at least one detailed example showing all steps in the testing cycle. You will also submit your most current KDD based on the results of your PDSAs and provide a run chart showing how your outcome has changed over time and annotating your testing cycles so that their impact on the SMART aim can be demonstrated. The run chart will be cumulative and should include any baseline data you were able to collect before you began testing. The first submission in October should therefore include at least 12 weeks of data, November will show approximately 16 weeks' worth, and so on, until the final submission at the end of June. The dates on the run chart should reflect the Friday ending the week and should include your denominator in parentheses after the date. An example is included at the end of this guidance.