THE OHIO DEPARTMENT OF MEDICAID
OHIO MEDICAL ASSISTANCE PROVIDER AGREEMENT
FOR MANAGED CARE PLAN

This Provider Agreement (herein "Provider Agreement" or "Agreement") is entered into this first day of July, 2015, at Columbus, Franklin County, Ohio, between the State of Ohio, The Ohio Department of Medicaid, (hereinafter referred to as ODM) whose principal offices are located in the City of Columbus, County of Franklin, State of Ohio, and _____, Managed Care Plan (hereinafter referred to as MCP), an Ohio corporation, whose principal office is located in the city of _____, County of _____, State of Ohio.

The MCP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751 of the Ohio Revised Code (ORC) and is organized and agrees to operate as prescribed by Chapter 5160-26 of the Ohio Administrative Code (OAC), and other applicable portions of the OAC as amended from time to time.

The MCP is an entity eligible to enter into a provider agreement in accordance with 42 CFR (Code of Federal Regulations) 438.6 and is engaged in the business of providing comprehensive health care services as defined in 42 CFR 438.2 through the managed care program for the Medicaid eligible population described in OAC rule 5160-26-02(B) and any other Medicaid eligible populations authorized by the Centers for Medicare and Medicaid Services (CMS) and described in Ohio's Medicaid State Plan.

ODM, as the single state agency designated to administer the Medicaid program under Section 5162.03 of the ORC and Title XIX of the Social Security Act, desires to obtain MCP services for the benefit of certain Medicaid recipients. In so doing, the MCP has provided and will continue to provide proof of the MCP's capability to provide quality services, efficiently, effectively and economically during the term of this Agreement.

This Provider Agreement is a contract between ODM and the undersigned MCP, provider of medical assistance, pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCP agrees to provide comprehensive Medicaid services through the managed care program as provided in Chapter 5160-26 of the OAC, assuming the risk of loss, and at all times complying with federal and state laws and regulations, federal and state Medicaid program requirements, and other requirements as specified by ODM. This includes without limitation Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

ARTICLE I - GENERAL

A. ODM enters into this Agreement in reliance upon the MCP's representations that it has the necessary expertise and experience to perform its obligations hereunder, and the MCP represents and warrants that it does possess such necessary expertise and experience.

B. The MCP agrees to communicate with the Chief of the Bureau of Managed Care (BMC) (hereinafter referred to as BMC) or his or her designee as necessary in order for the MCP to assure its understanding of the responsibilities and satisfactory compliance with this Provider Agreement.

C. The MCP agrees to furnish its staff and services as necessary for the satisfactory performance of the services as enumerated in this Provider Agreement.

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

ARTICLE II - TIME OF PERFORMANCE

A. Upon approval by the Director of ODM this Provider Agreement shall be in effect from the date executed through June 30, 2016, unless this Provider Agreement is suspended or terminated pursuant to Article VIII prior to the termination date, or otherwise amended pursuant to Article IX.

ARTICLE III - REIMBURSEMENT

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

ARTICLE IV - RELATIONSHIP OF PARTIES

A. ODM and the MCP agree that, during the term of this Agreement, the MCP shall be engaged with ODM solely on an independent contractor basis, and neither the MCP nor its personnel shall, at any time or for any purpose, be considered as agents, servants or employees of ODM or the state of Ohio. The MCP shall therefore be responsible for all the MCP's business expenses, including, but not limited to, employee's wages and salaries, insurance of every type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any. Pursuant to ORC 145.038, ODM is required to provide individuals and business entities with fewer than five employees the Independent Contractor Acknowledgment (Form PEDACKN). This form requires the MCP to acknowledge that ODM has notified the MCP that it has not been classified as a public employee and no Ohio Public Employees Retirement System (OPERS) contributions will be made on behalf of the MCP, its employees, or its subcontractors for

these services. If the MCP is a business entity with fewer than five employees, each employee must complete the PEDACKN form.

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

C. ODM retains the right to ensure that the MCP's work is in conformity with the terms and conditions of this Agreement.

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

ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS

A. In accordance with the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) and other applicable federal requirements, no officer, member or employee of the MCP, the Chief of BMC, or other ODM employee who exercises any functions or responsibilities in connection with the review or approval of this Provider Agreement or provision of services under this Provider Agreement shall, prior to the completion of such services or reimbursement, acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with, or would compromise in any manner or degree the discharge and fulfillment of his or her functions and responsibilities with respect to the carrying out of such services. For purposes of this article, "members" does not include individuals whose sole connection with the MCP is the receipt of services through a health care program offered by the MCP.

B. The MCP represents, warrants, and certifies that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws and Executive Order 2011-03K. The MCP further represents, warrants, and certifies that neither the MCP nor any of its employees will do any act or omit any action that is inconsistent with such laws and Executive Order. The Governor's Executive Orders may be found by accessing the following website: http://governor.ohio.gov/ExecutiveOrders.aspx

C. The MCP hereby covenants that the MCP, its officers, members and employees of the MCP, shall not, prior to the completion of the work under this Agreement, voluntarily acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of his or her functions and responsibilities under this Provider Agreement. The MCP shall periodically inquire of its officers, members and employees concerning such interests.

D. Any such person who acquires an incompatible, compromising or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, shall immediately disclose his or her interest to ODM in writing. Thereafter, he or she shall not participate in any

action affecting the services under this Provider Agreement, unless ODM shall determine in its sole discretion that, in the light of the personal interest disclosed, his or her participation in any such action would not be contrary to the public interest. The written disclosure of such interest shall be made to: Chief, BMC, ODM.

E. No officer, member or employee of the MCP shall promise or give to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. The MCP, along with its officers, members and employees, understand and agree to take no action, or cause ODM or its employees to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws including without limitation those provisions found in Chapter 102 and Chapter 2921 of the ORC.

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

ARTICLE VI - NONDISCRIMINATION OF EMPLOYMENT

A. The MCP agrees that in the performance of this Provider Agreement or in the hiring of any employees for the performance of services under this Provider Agreement, the MCP shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry, discriminate against any individual in the employment of an individual who is qualified and available to perform the services to which the Provider Agreement relates.

B. The MCP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the Provider Agreement on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry.

C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5160-26, the MCP agrees to hold all subcontractors and persons acting on behalf of the MCP in the performance of services under this Provider Agreement responsible for adhering to the requirements of paragraphs (A) and (B) above and shall include the requirements of paragraphs (A) and (B) above in all subcontracts for services performed under this Provider Agreement, in accordance with OAC rule 5160-26-05.

ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION

A. The MCP agrees that all records, documents, writings or other information produced by the MCP under this Provider Agreement and all records, documents, writings or other information used by the MCP in the performance of this Provider Agreement shall be treated in accordance with OAC rule 5160-26-06 and must be provided to ODM, or its

designee, if requested. The MCP must maintain an appropriate record system for services provided to members. The MCP must retain all records in accordance with 45 CFR 74.53.

B. All information provided by the MCP to ODM that is proprietary shall be held to be strictly confidential by ODM. Proprietary information is information which, if made public, would put the MCP at a disadvantage in the market place and trade of which the MCP is a part [see ORC Section 1333.61(D)]. The MCP agrees to expressly indicate by marking the top or bottom of each individual record containing information the MCP deems proprietary or trade secret, regardless of media type (CD-ROM, Excel file etc.) prior to its release to ODM. Upon request from ODM, the MCP agrees to promptly notify ODM in writing of the nature of the proprietary information including all reasonable evidence regarding the nature of the proprietary information in records submitted to ODM. The MCP also agrees to provide for the legal defense of all proprietary information submitted to ODM. ODM shall promptly notify the MCP in writing or via email of the need to legally defend the proprietary information such that the MCP is afforded the opportunity to adequately defend such information. Failure to provide such prior notification or failure to legally defend the proprietary nature of such information is deemed to be a waiver of the proprietary nature of the information, and a waiver of any right of the MCP to proceed against ODM for violation of this Provider Agreement or of any proprietary or trade secret laws. Such failure shall also be deemed a waiver of trade secret protection in that the MCP will have failed to make efforts that are reasonable under the circumstances to maintain the information's secrecy. ODM will make the final determination of whether any or all of the information identified by the MCP is proprietary or a trade secret. The provisions of this Article are not self-executing.

C. The MCP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Provider Agreement. The MCP agrees to be bound by the same standards of confidentiality that apply to the employees of ODM and the State of Ohio, including without limitation the confidentiality requirements found in 42 CFR Part 431 Subpart F and ORC 5160.45, as well as 42 C.F.R. 2.12 and ORC 5119.27, as applicable. The terms of this section shall be included in any subcontracts executed by the MCP for services under this Provider Agreement. The MCP must implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

D. The MCP agrees, certifies and affirms that HHS, US Comptroller General or representatives will have access to books, documents, and other business records of the MCP.

E. All records relating to performance, under or pertaining to this Provider Agreement will be retained by the MCP in accordance to the appropriate records retention schedule. The appropriate records retention schedule for this Provider Agreement is for a total period of eight (8) years. For the initial three (3) years of the retention period, the records must be stored in a manner and place that provides readily available access. If any records are

destroyed prior to the date as determined by the appropriate records retention schedule, the MCP agrees to pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.

F. The MCP agrees to retain all records in accordance with any litigation holds that are provided to them by ODM, and actively participate in the discovery process if required to do so, at no additional charge. Litigation holds may require the MCP to keep the records longer then the approved records retention schedule. The MCP will be notified by ODM when the litigation hold ends and retention can resume based on the approved records retention schedule. If the MCP fails to retain the pertinent records after receiving a litigation hold from ODM, the MCP agrees to pay to ODM all damages, costs and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.

G. The MCP shall promptly notify ODM of any legal matters and administrative proceedings including, but not limited to, litigation and arbitration, which involve or otherwise pertain to the activities performed pursuant to this Provider Agreement and any third party. In the event that the MCP possesses or has access to information and/or documentation needed by ODM with regard to the above, the MCP agrees to cooperate with ODM in gathering and providing such information and/or documentation to the extent permissible under applicable law.

ARTICLE VIII - NONRENEWAL AND TERMINATION

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

B. Subsequent to receiving a notice of termination from ODM, the MCP beginning on the effective date of the termination, shall cease provision of services on the terminated activities under this Provider Agreement; terminate all subcontracts relating to such terminated activities, take all necessary or appropriate steps to limit disbursements and minimize costs, and comply with the requirements specified in this Provider Agreement, as of the date of receipt of notice of termination describing the status of all services under this Provider Agreement.

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

D. In the event of termination under this Article, MCP shall return all records in their native format relating to cost, work performed, supporting documentation for invoices submitted

to ODM, and copies of all materials produced under or pertaining to this Provider Agreement.

E. ODM may, in its sole discretion, terminate or fail to renew this Provider Agreement if the MCP or MCP's subcontractors violate or fail to comply with the provisions of this Agreement or other provisions of law or regulation governing the Medicaid program. Where ODM proposes to terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the OAC with respect to ODM's suspension, termination or refusal to enter into a provider agreement shall apply, including the MCP's right to request an adjudication hearing under Chapter 119 of the ORC. The MCP does not have the right to request an adjudication hearing under Chapter 119 of the ORC to challenge any action taken or decision made by ODM with respect to entering into or refusing to enter into a provider agreement with the MCP pursuant to section 5167.10 of the Revised Code.

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

G. The MCP understands that availability of funds to fulfill the terms of this Provider Agreement is contingent on appropriations made by the Ohio General Assembly and the United States government for funding the Medicaid program. If sufficient funds are not available from the Ohio General Assembly or the United States government to make payments on behalf of a specific population (Aged, Blind, Disabled, Covered Families and Children, or Adult Extension) to fulfill the terms of this Provider Agreement, the obligations, duties and responsibilities of the parties with respect to that population will be terminated except as specified in Appendix P as of the date funding expires. If the Ohio General Assembly or the United States government fails at any time to provide sufficient funding for ODM or the State of Ohio to make payments due under this Provider Agreement, this Provider Agreement will terminate as of the date funding expires without further obligation of ODM or the State of Ohio.

ARTICLE IX - AMENDMENT AND RENEWAL

A. This writing constitutes the entire Agreement between the parties with respect to all matters herein. This Provider Agreement may be amended only by a writing signed by both parties. Any written amendments to this Provider Agreement shall be prospective in nature.

B. In the event that changes in state or federal law, regulations, an applicable waiver or state plan amendment, or the terms and conditions of any applicable federal waiver or state plan amendment, require ODM to modify this Agreement, ODM shall notify the MCP regarding such changes and this Agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this Article of this Agreement.

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

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

E. If the MCP was not selected as a contractor as a result of a procurement process, the expiration of this Agreement shall not be considered a termination or failure to renew. The MCP will have the ability to protest the award of the contract in accordance with the process that will be described in the Request for Applications.

ARTICLE X - LIMITATION OF LIABILITY

A. The MCP agrees to indemnify and to hold ODM and the state of Ohio harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of the MCP in the fulfillment of this Provider Agreement or arising from this Agreement which are attributable to the MCP's own actions or omissions, or of those of its trustees, officers, employees, agents, subcontractors, suppliers, third parties utilized by the MCP, or joint ventures. Such claims shall include but are not limited to: any claims made under the Fair Labor Standards Act or under any other federal or state law involving wages, overtime, or employment matters and any claims involving patents, copyrights, trademarks and applicable public records laws. The MCP shall bear all costs associated with defending ODM and the state of Ohio against these claims.

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

C. In the event that, due to circumstances not reasonably within the control of the MCP or ODM, a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection occurs, neither ODM nor the MCP will have any liability or obligation

on account of reasonable delay in the provision or the arrangement of covered services; provided that so long as the MCP's Certificate of Authority remains in full force and effect, the MCP shall be liable for the covered services required to be provided or arranged for in accordance with this Agreement.

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

ARTICLE XI - ASSIGNMENT

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

B. The MCP shall not assign any interest in subcontracts of this Provider Agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODM and subject to such conditions and provisions as ODM may deem necessary. Any such assignments of subcontracts shall be submitted for ODM's review 30 days prior to the desired effective date. No such approval by ODM of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODM in addition to the total agreed-upon reimbursement in accordance with this Agreement.

ARTICLE XII - CERTIFICATION MADE BY THE MCP

A. This Agreement is conditioned upon the full disclosure by the MCP to ODM of all information required for compliance with state and federal regulations.

B. The MCP certifies that no federal funds paid to the MCP through this or any other Agreement with ODM shall be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement or loan. The MCP

further certifies its continuing compliance with applicable lobbying restrictions contained in 31 U.S.C. 1352 and 45 CFR Part 93. If this Agreement exceeds $100,000, the MCP has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. This certification is material representation of fact upon which reliance was placed when this Provider Agreement was entered into.

C. The MCP certifies that neither the MCP nor any principals of the MCP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal agency. The MCP also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC Section 153.02 or ORC Section 125.25. The MCP also certifies that the MCP has no employment, consulting or any other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the MCP's contractual obligation with ODM. This certification is a material representation of fact upon which reliance was placed when this Provider Agreement was entered into. Federal financial participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services. If it is ever determined that the MCP knowingly executed this certification erroneously, then in addition to any other remedies, this Provider Agreement shall be terminated pursuant to Article VIII, and ODM must advise the Secretary of the appropriate federal agency of the knowingly erroneous certification.

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

E. The MCP agrees not to discriminate against individuals who have or are participating in any work program administered by a County Department of Job and Family Services (CDJFS) under Chapters 5101 or 5107 of the ORC.

F. The MCP certifies and affirms that, as applicable to the MCP, that no party listed or described in Division (I) or (J) of Section 3517.13 of the ORC who was in a listed position at the time of the contribution, has made as an individual, within the two previous calendar years, one or more contributions in excess of one thousand and 00/100 ($1,000.00) to the present governor or to the governor's campaign committees during any time he/she was a candidate for office. This certification is a material representation of fact upon which reliance was placed when this Provider Agreement was entered into. If it is ever determined that the MCP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, the MCP shall return to ODM all monies paid to the MCP under this Provider Agreement. The provisions of this section shall survive the expiration or termination of this Provider Agreement.

G. The MCP agrees to refrain from promising or giving to any ODM employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties.

H. The MCP agrees to comply with the false claims recovery requirements of 42 U.S.C 1396a(a)(68) and to also comply with ORC 5162.15.

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

J. The MCP certifies and confirms that any performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention.

K. The MCP certifies and confirms that it agrees to comply with all applicable standards orders or regulations of the Clean Air Act and Federal Water Pollution Control Act.

L. The MCP agrees that it is in compliance with the Federal Acquisition Regulation (FAR) for Combatting Trafficking in Persons, 48 CFR Subpart 22.17, in which "the United States Government has adopted a zero tolerance policy regarding trafficking in persons." The provisions found in 48 CFR Subpart 52.2, specifically Subpart 52.222-50 are hereby incorporated into this Agreement by reference. ODM reserves the right to immediately and unilaterally terminate this Agreement if any provision in this Section is violated and ODM may implement section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 USC 7104), *see* 2 CFR Part 175.

ARTICLE XIII - CONSTRUCTION

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

ARTICLE XIV - INCORPORATION BY REFERENCE

A. OAC Chapter 5160-26 is hereby incorporated by reference as part of this Provider Agreement having the full force and effect as if specifically restated herein.

B. Appendices A through Q and any additional appendices are hereby incorporated by reference as part of this Provider Agreement having the full force and effect as if specifically restated herein. Appendix P and any other applicable obligations set forth in this Provider Agreement will survive the termination or non-renewal of this Agreement.

C. In the event of inconsistence or ambiguity between the provisions of OAC Chapter 5160-26 and this Agreement, the provisions of OAC Chapter 5160-26 shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, as provided in Article IX of this Provider Agreement, in which case such federal or state law shall be determinative of the obligations of the parties. In the event OAC 5160-26 is silent with respect to any ambiguity or inconsistency, the Agreement (including Appendices B through Q and any additional appendices), shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the Provider Agreement and the budgetary and statutory constraints of ODM.

ARTICLE XV – NOTICES

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

ARTICLE XVI – HEADINGS

The headings in this Agreement have been inserted for convenient reference only and shall not be considered in any questions of interpretation or construction of this Agreement.
The parties have executed this Agreement the date first written above. The Agreement is hereby accepted and considered binding in accordance with the terms and conditions set forth in the preceding statements.

Intentionally blank.

MANAGED CARE PLAN:

BY: _____ DATE: _____
_____, PRESIDENT/CEO

_____, ADDRESS

THE OHIO DEPARTMENT OF MEDICAID:

BY: _____ DATE: _____
JOHN B. MCCARTHY, MEDICAID DIRECTOR

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

Ohio Department of Medicaid (ODM)
Medicaid Managed Care Provider Agreement
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APPENDIX A

OAC RULES 5160-26

The managed care program rules can be accessed electronically through the Ohio Department of Medicaid's Managed Care webpage.

APPENDIX B

SERVICE AREA SPECIFICATIONS

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

Service Area	
Central/Southeast Region	☒
Northeast Region	☒
West Region	☒

The ABD and CFC categories of assistance are described in OAC rule 5160-26-02(B). The Adult Extension category is defined in Ohio's Medicaid State Plan as authorized by the Centers for Medicare and Medicaid Services (CMS).

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

OHIO MCP REGIONS

Counties in the Central/Southeast Region

Athens	Jackson	Muskingum
Belmont	Jefferson	Noble
Coshocton	Knox	Perry
Crawford	Lawrence	Pickaway
Delaware	Licking	Pike
Fairfield	Logan	Ross
Fayette	Madison	Scioto
Franklin	Marion	Union
Gallia	Morrow	Vinton
Guernsey	Meigs	Washington
Harrison	Monroe	
Hocking	Morgan	

Counties in the Northeast Region

Ashland	Geauga	Richland
Ashtabula	Huron	Stark
Carroll	Lake	Summit
Columbiana	Lorain	Trumbull
Cuyahoga	Portage	Tuscarawas
Erie	Medina	Wayne
Holmes	Mahoning	

Counties in the West Region

Adams	Fulton	Ottawa
Allen	Greene	Paulding
Auglaize	Hamilton	Preble
Brown	Hancock	Putnam
Butler	Hardin	Sandusky
Champaign	Henry	Seneca
Clark	Highland	Shelby
Clermont	Lucas	Van Wert
Clinton	Mercer	Williams
Darke	Miami	Wood
Defiance	Montgomery	Wyandot
		Warren

APPENDIX C

MCP RESPONSIBILITIES

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

General Provisions

1. The MCP agrees to implement program modifications as soon as reasonably possible or no later than the required effective date, in response to changes in applicable state and federal laws and regulations.

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

3. The MCP must designate the following:

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

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

4. Communications: The MCP must take all necessary and appropriate steps to ensure that all MCP staff are aware of, and follow, the following communication process:

    a. All MCP employees are to direct all day-to-day submissions and communications to their ODM-designated Contract Administrator within the Bureau of Managed Care (BMC) unless otherwise notified by ODM.

    b. Entities that contract with ODM should never be contacted by the MCP unless ODM has specifically instructed the MCP to contact these entities directly.

    c. Because the MCP is ultimately responsible for meeting program requirements, the BMC will not discuss MCP issues with the MCP's subcontractors unless the MCP is also participating in the discussion. MCP delegated entities, with the MCP participating, should only communicate with the specific Contract Administrator assigned to that MCP.

5. The MCP must be represented at all meetings and events designated by ODM that require mandatory attendance.

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

7. The MCP must have its Ohio Medicaid Managed Care program member call center(s) located in the state of Ohio.

8. The MCP must have the key Ohio Medicaid Managed Care program staff identified below based and working in the state of Ohio. Each key staff person identified below may occupy no more than one of the positions listed below, unless the MCP receives prior written approval from ODM stating otherwise. These key staff are:

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

    b. **Medical Director/CMO** who is a physician with a current, unencumbered license through the Ohio State Medical Board. The Medical Director must have at least three (3) years of training in a medical specialty. The Medical Director shall devote full time (minimum 32 hours weekly) to the MCP's operations to ensure timely medical decisions, including after-hours consultation as needed. The Medical Director shall be actively involved in all major clinical and quality management components of the MCP. At a minimum, the Medical Director shall be responsible for:
        i. Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the MCP grievance system;
        ii. Administration of all medical management activities of the MCP; and
        iii. Serve as director of the Utilization Management committee and chairman or co-chairman of the Quality Assessment and Performance Improvement committee.

    c. **Contract Compliance Officer** who will serve as the primary point-of-contact for all MCP operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinating the tracking and submission of all contract deliverables; fielding and coordinating responses to ODM inquiries, coordinating the preparation and execution of contract requirements, random and periodic audits and site visits.

d. **Provider Services Representatives** who will resolve provider issues, including, but not limited to, problems with claims payment, prior authorizations and referrals.

e. **Care Management Director** who is an Ohio-licensed registered nurse preferably with a designation as a Certified Case Manager (CCM) from the Commission for Case Manager Certification (CCMC). The Director is responsible for overseeing the day-to-day operational activities of the Care Management Program in accordance with state guidelines. The CM Director is responsible for ensuring the functioning of care management activities across the continuum of care (assessing, planning, implementing, coordinating, monitoring, and evaluating).The CM Director must have experience in the activities of care management as specified in 42 CFR §438.208. Primary functions of the Director position are:
   i. To ensure the implementation of mechanisms for identifying, assessing, and developing a treatment plan for an individual with special health care needs;
   ii. To ensure access to primary care and coordination of health care services for all members; and
   iii. To ensure the coordination of services furnished to the enrollee with the services the enrollee receives from any other health care entity.

f. **Utilization Management Director** who is an Ohio-licensed registered nurse or a physician with a current unencumbered license through the Ohio State Medical Board. This person may have a certification as a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The Director is responsible for overseeing the day-to-day operational activities of the Utilization Management Program in accordance with state guidelines. The UM Director must have experience in the activities of utilization management as specified in 42 CFR §438.210. Primary functions of the Director of Utilization Management position are:
   i. To ensure that there are written policies and procedures regarding authorization of services and that these are followed;
   ii. To ensure consistent application of review criteria for authorization decisions;
   iii. To ensure that decisions to deny or reduce the amount of services are made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;
   iv. To ensure that notices of adverse action meet the requirements of §438.404; and
   v. To ensure that all decisions are made within the specified allowable time frames.

g. **EPSDT/Maternal Child Health Manager** who is an Ohio licensed registered nurse, physician, or physician's assistant; or has a Master's degree in health services, public health, or health care administration or other related field and/or a CPHQ or CHCQM. Staffing under this position should be sufficient to meet quality and performance measure goals. The primary functions of the EPSDT/MCH Manager are:
   i. Ensuring receipt of EPSDT services;
   ii. Ensuring receipt of maternal and postpartum care;
   iii. Promoting family planning services;
   iv. Promoting preventive health strategies;
   v. Identifying and coordinating assistance for identified member needs specific to maternal/child health and EPSDT; Interfacing with community partners; and
   vi. Pregnancy Related Services Coordinator

h. **Quality Improvement Director** who is an Ohio-licensed registered nurse, physician or physician's assistant or is a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The Quality Improvement Director must have experience in quality management and quality improvement as specified in 42 CFR §438.200 – 438.242. The primary functions of the Quality Improvement Director position are:
   i. Ensuring individual and systemic quality of care;
   ii. Integrating quality throughout the organization;
   iii. Implementing process improvement; and
   iv. Resolving, tracking and trending quality of care grievances.

9. Upon request by ODM, the MCP must submit information on the current status of their company's operations not specifically covered under this Agreement unless otherwise excluded by law.

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

11. All employees of the MCP and the MCP's subcontractors who have in-person contact with a member in the member's home must comply with criminal record check requirements as specified by ODM.

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

well as all marketing materials, will need to include information specifying any such services that the MCP will not provide.

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

14. The MCP is responsible for determining medical necessity for services and supplies requested for their members as specified in OAC rule 5160-26-03. Notwithstanding such responsibility, ODM retains the right to make the final determination on medical necessity in specific member situations.

15. The MCP must submit medical records at no cost to ODM and/or its designee upon request.

16. In addition to the provisions in OAC 5160-26-05(B), the MCP must notify the BMC:

    a. within one working day of becoming aware that a MCP panel provider that served 500 or more of the MCP's members failed to notify the MCP that they are no longer available to serve as a MCP panel provider;

    b. at least 4 months before the effective date of a MCP-initiated termination or change in availability of any provider, or combination of providers in the case of a systemic change in panel, that serves 500 or more of the MCP's members; or

    c. within one working day of becoming aware of a provider-initiated hospital unit closure.

    ODM reserves the right to require that the MCP align a MCP-initiated termination or change in availability that impacts 500 or more members to the annual open enrollment month.

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

18. <u>Additional Benefits:</u> The MCP may elect to provide services that are in addition to those covered under the Ohio Medicaid fee-for-service (FFS) program. Before the MCP notifies potential or current members of the availability of these services, they must first notify ODM and advise ODM that it plans to make such services available. If an 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. Additional benefits may not vary by

county within a region except out of necessity for transportation arrangements (e.g., bus versus cab). MCPs approved to serve consumers in more than one region may vary additional benefits between regions.

a. The MCP is **required** to make transportation available to any member requesting transportation when the member **must** travel thirty (30) miles or more from his or her home to receive a medically-necessary Medicaid-covered service provided by the MCP pursuant to OAC rule 5160-26-03 and Appendix G of this Provider Agreement. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.

b. The MCP must give ODM and members ninety (90) days prior notice when decreasing or ceasing any additional benefit(s). 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 (1) working day.

19. Provision of Transportation Services:

a. MCPs must ensure transportation pick-up is completed not more than fifteen (15) minutes before or fifteen (15) minutes after the pre-scheduled pick-up time, ensuring the member is on time for their appointment, and no more than thirty (30) minutes after a request for pick-up following a scheduled appointment. The vendor must attempt to contact the member if he/she does not respond at pick-up. The vendor must not leave the pick-up location prior to the pre-scheduled pick-up time. The MCPs must identify and accommodate the special transportation assistance needs of their members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements). Member-specific needs must be communicated to the transportation vendor and updated as frequently as is needed to support the member's needs. Where applicable, these needs must be documented in the member's care plan.

b. MCPs must submit a plan for the provision of transportation services during winter snow and other weather emergencies, specifying identification, triage, transportation of consumers requiring critical services, notification to consumers of canceled transportation and rescheduling. The plan must specify the snow emergency level and any other weather-related criteria that require a change to scheduled transportation. The MCP must notify the Contract Administrator immediately when transportation is canceled in accordance with the plan.

20. The MCP must comply with any applicable federal and state laws that pertain to member rights and ensure that its staff adheres to such laws when furnishing services to its members. The MCP shall include a requirement in its contracts with affiliated providers

that such providers also adhere to applicable Federal and State laws when providing services to members.

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

22. Marketing Materials and Member Materials

Pursuant to OAC rules 5160-26-08 and 5160-26-08.2, the MCP is responsible for ensuring that all MCP marketing and member materials are prior approved by ODM before being used or shared with members or potential members. Member materials must be available in written format, but can be provided to the member in alternative formats (e.g., CD-ROM) if specifically requested by the member, except as specified in OAC rule 5160-26-08.4. Marketing and member materials are defined as follows:

a. Marketing materials are those items produced in any medium, by or on behalf of an MCP, including gifts of nominal value (i.e., items worth no more than $15.00), which can reasonably be interpreted as intended to market to eligible individuals as defined in OAC 5160-26-01.

b. Member materials are those items developed, by or on behalf of an MCP, to fulfill MCP program requirements or to communicate to all members or a group of members. Member health education materials that are produced by a source other than the MCP and which do not include any reference to the MCP are not considered to be member materials.

c. MCP marketing and member materials must not include statements that are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODM.

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

e. The MCP must establish positive working relationships with the County Department of Job and Family Services (CDJFS) offices and must not aggressively solicit from local Directors, MCP County Coordinators, or other staff. Furthermore, the MCP is prohibited from offering gifts to CDJFS offices or Medicaid Consumer Hotline (henceforth referred to as the “Hotline”) staff, as these may influence an individual’s decision to select a particular MCP.

f. MCP marketing representatives and other MCP staff are prohibited from offering eligible individuals the use of a portable device (laptop computer, cellular phone, etc.) to assist with the completion of an online application to select and/or change MCPs, as all enrollment activities must be completed by the Hotline.

23. Cultural Competency and Communication Needs

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

The MCP must comply with the requirements specified in OAC rules 5160-26-03.1, 5160-26-05(D), 5160-26-05.1(A), 5160-26-08 and 5160-26-08.2 for providing assistance to LEP members and eligible individuals. 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:

a. If ODM identifies prevalent common primary languages other than English in the MCP's service area, the MCP, as specified by ODM, must translate marketing and member materials, including but not limited to HIPAA privacy notices, into the primary languages of those groups and make these marketing and member materials available to eligible individuals free of charge.

b. 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).

Additional requirements specific to providing assistance to hearing-impaired, vision-impaired, LRP, and LEP members and eligible individuals are found in

OAC rules 5160-26-03.1, 5160-26-05(D), 5160-26-05.1(A), 5160-26-08, and 5160-26-08.2.

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

d. The MCP must participate in ODM's cultural competency initiatives.

e. Person-Centered Language in Communications - The MCP will use person-centered language in all communication with eligible individuals and members consistent with the definition available at: http://www.disabilityisnatural.com/explore/professionals-organizations.

24. New Member Materials

Pursuant to OAC rule 5160-26-08.2(B)(3), MCPs must provide to each member or assistance group, as applicable, an MCP identification (ID) card, a new member letter, a member handbook, provider panel information, and information on advance directives, as specified by ODM.

a. The MCP must use the model language specified by ODM for the new member letter.

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

c. The MCP must provide access to provider panel information to members via the MCP's website and printed provider directories.

i. MCPs may mail ODM prior-approved postcards to new members in lieu of mailing printed directories. At a minimum, the postcards must advise members to call the MCP or return the postcards to request a printed provider directory. MCPs must automatically send a printed provider directory to members that voluntarily enroll and request a printed provider directory, as reflected on the Consumer Contact Record (CCR), with the new member materials as specified in 24.d. of this Appendix.

ii. MCPs that do not use an ODM prior-approved postcard must mail printed provider directories to all new members as specified in 24.d. of this Appendix except printed provider directories do not need to be mailed to new members that voluntarily enroll and request to not receive printed provider directories as reflected on the CCR.

iii. If requested, a printed provider directory must be sent to a member within seven (7) calendar days of the request.

d. The MCP may mail the member handbook, provider directory, if applicable, and advance directives information to the member separately from the ID card, new member letter, and provider directory request postcard if applicable. An MCP will meet the timeliness requirement for mailing these materials if they are mailed to the member within twenty-four (24) hours of the MCP receiving the ODM produced monthly full-membership roster, which is the HIPAA 834 F, and if the materials are mailed via a method with an expected delivery date of no more than five (5) days. If the MCP mails the member handbook, provider directory (if applicable), and advance directives information separately from the ID card, new member letter, and postcard (if applicable), but the MCP is unable to mail these materials within twenty-four (24) hours of receiving the HIPAA 834 F, the MCP must mail the member handbook, provider directory (if applicable), and advance directives information via a method that will ensure receipt by no later than the effective date of coverage. If the MCP mails the ID card, new member letter, and postcard (if applicable), with the other materials (e.g., member handbook, provider directory, and advance directives), the MCP must ensure that all materials are mailed via a method that will ensure their receipt prior to the member's effective date of coverage.

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

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

25. Healthchek Services

a. Informing Members About Healthchek - In addition to the Healthchek requirements specified in OAC rules 5160-26-03(H) and 5160-26-08.2(B)(4)(i), the MCP must:

i. Inform each member under the age of 21 within 7 calendar days of their effective date of enrollment in the MCP about the Healthchek program as prescribed by ODM and as specified by 42 C.F.R. Section 441.56. An MCP may meet this requirement by including information with the new member materials as specified in paragraph 24.d of this Appendix. In addition, the MCP must communicate with the member's local County Department of Job and Family Services agency any requests made by the member for County coordinated services and/or supports (e.g. social services).

ii. Provide members with accurate information in the member handbook regarding Healthchek, Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. The MCP's member handbooks must be provided to members within the time frames specified in 24.d of this Appendix, and must include verbatim the model language developed by ODM. The model language at a minimum will include:

a. A description of the types of screening and treatment services covered by Healthchek;
b. A list of the intervals at which individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document entitled "Recommendations for Preventive Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics;
c. Information that Healthchek services are provided at no additional cost to the member; and
d. Information that providers may request prior authorization for coverage of services that have limitations and/or are not covered for members age 21 and older if the services are medically necessary EPSDT services.

iii. Provide the above Healthchek information in 25.a.ii on the MCP's member website specified in 41.b. of this Appendix.

iv. Deliver Healthchek information as provided, or as approved, by ODM to its members at the following intervals:
a. When the member is 9 months old;
b. When the member is 18 months old;
c. When the member is 30 months old;
d. January of each calendar year to all members under the age of 21; and
e. At the beginning of each school year in the month of July for members from age 4 to under 21.

The mailing templates provided by ODM will not exceed two (2) 8x11 pages for each mailing with most mailings being one (1) page or less in length. The MCP must populate the materials with appropriate Healthchek information as required (e. g. type of service, rendering provider, date of service and age of member on the date of service).

d. Informing Members about Pregnancy Related Services (PRS)
i. Upon the identification of a member as pregnant, the MCP must deliver to the member within 14 calendar days a PRS form as designated by ODM. The MCP must communicate with the member's local County Department

of Job and Family Services agency any requests made by the member for County coordinated services and supports (e.g. social services).

c.. Informing Providers about Healthchek -- In addition to the Healthchek requirements specified in OAC rule 5160-26-05.1(A)(13), the MCP must:

i. Provide Healthchek education to all contracted providers on an annual basis which must include, at a minimum, the following:

a. The required components of a Healthchek exam as specified in Ohio Administrative Code Chapter 5160-3-14;

b. A list of the intervals at which individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document "Recommendations for Preventive Pediatric Health Care" published by Bright Futures/American Academy of Pediatrics;

c. A statement that Healthchek includes a range of medically necessary screening, diagnosis and treatment services; and

d. A list of common billing codes and procedures related to the Healthchek services (e.g., immunizations, well child exams, laboratory tests, and screenings).

ii. Provide the above information on the MCP's provider website as specified in 41.c. of this Appendix.

26. Advance Directives

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

a. Maintain written policies and procedures that meet the requirements for advance directives, as set forth in 42 CFR Subpart I of part 489 (42 CFR 489.100—489.104).

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

i. Provides written ODM-approved information to all adult members concerning:

a. The member's rights under state law to make decisions concerning his or her medical care, including the right to

accept or refuse medical or surgical treatment and the right to formulate advance directives.

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

c. Any changes in state law regarding advance directives as soon as possible, but no later than ninety (90) days after the proposed effective date of the change; and

d. The right to file complaints concerning noncompliance with the advance directive requirements with the Ohio Department of Health.

ii. Provides for education of staff concerning the MCP's policies and procedures on advance directives;

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

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

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

27. Call Center Standards

The MCP must provide assistance to members through a member services toll-free call-in system pursuant to OAC rule 5160-26-08.2(A)(1). MCP member services staff must be available nationwide to provide assistance to members through the toll-free call-in system every Monday through Friday, at all times during the hours of 7:00 am to 7:00 pm Eastern Time, except for the following major holidays:

- New Year's Day
- Martin Luther King's Birthday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

- 2 optional closure days: These days can be used independently or in combination with any of the major holiday closures, but cannot both be used within the same closure period. Before announcing any optional closure dates to members and/or staff, MCPs must receive ODM prior approval which verifies that the optional closure days meet the specified criteria.

If a major holiday falls on a Saturday, the MCP member services line may be closed on the preceding Friday. If a major holiday falls on a Sunday, the member services line may be closed on the following Monday. MCP member services closure days must be specified in the MCP's member handbook, member newsletter, or other some general issuance to the MCP's members at least thirty (30) days in advance of the closure. The MCP must request prior approval from ODM of anyextended hours of operation of the member services line that is outside the required days and time specified above.

The MCP must also provide access to medical advice and direction through a centralized twenty-four-hour, seven day (24/7), toll-free call-in system, available nationwide, pursuant to OAC rule 5160-26-03.1(A)(6). The 24/7 call-in system must be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs).

The MCP must meet the current American Accreditation HealthCare Commission/URAC-designed Health Call Center Standards (HCC) for call center abandonment rate, blockage rate and average speed of answer. By the 10th of each month, the MCP must self-report its prior month performance in these three areas for their member services and 24/7 hour toll-free call-in systems to ODM. If an MCP has separate telephone lines for different Medicaid populations, the MCP must report performance for each individual line separately. ODM will inform the MCPs of any changes/updates to these URAC call center standards.

The member services call center requirement may not be met through the execution of a Medicaid Delegation Subcontract Addendum or Medicaid Combined Services Subcontract Addendum. With the exception of transportation vendors, MCPs are prohibited from publishing a delegated entity's general call center number.

28. <u>Notification of Optional MCP Membership</u>

In order to comply with the terms of the ODM State Plan Amendment for the managed care program (i.e., 42 CFR 438.50), the MCP must inform new members that MCP membership is optional for certain populations.

Specifically, the MCP must inform any applicable ABD or CFC pending member or member that the following population is not required to select an MCP in order to receive

their Medicaid healthcare benefit and what steps they need to take if they do not wish to be a member of an MCP:

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

Additionally, the MCP must inform any applicable CFC pending member or member that the following populations are not required to select an MCP in order to receive their Medicaid healthcare benefits, and describe what steps the member must take if he or she does not wish to become a member of an MCP:

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

29. Privacy Compliance Requirements

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

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

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

a. **Permitted Uses and Disclosures.** The MCP will not use or disclose PHI except as provided in this Agreement or as otherwise required under HIPAA regulations or other applicable law.

b. **Safeguards.** The MCP shall implement sufficient safeguards, and comply with Subpart C of 45 CFR Part 164 pertaining to electronic PHI to prevent the use or disclosure of PHI other than as provided for under this Agreement. Safeguards will be implemented for all paper and electronic PHI created, received, maintained, or transmitted on behalf of ODM.

c. **Reporting of Disclosures.** The MCP agrees to promptly report to ODM any inappropriate use or disclosure of PHI that is not in accordance with this Agreement or applicable law, including a breach of unsecured PHI as required at 45 CFR 164.410 and any security incident the MCP has knowledge of or reasonably should have knowledge of under the circumstances.

d. **Mitigation Procedures.** The MCP agrees to coordinate with ODM to determine specific actions that will be required of the Business Associates for mitigation, to the extent practical, of the breach. These actions will include notification to the appropriate individuals, entities, or other authorities. Notification or communication to any media outlet must be approved, in writing, by ODM prior to any such communication being released. The MCP must report all of its mitigation activity to ODM and must preserve all relevant records and evidence.

e. **Incidental Costs.** The MCP shall bear the sole expense of all costs to mitigate any harmful effect, of any breaches or security incidents which were caused by the MCP, or its subcontractors, in violation of the terms of this Agreement. These costs will include, but are not limited to, the cost of investigation, remediation and assistance to the affected individuals, entities or other authorities.

f. **Agents and Subcontractors.** The MCP, in compliance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2) as applicable, must ensure that all its agents and subcontractors that create, receive, maintain, or transmit PHI from or on behalf of MCP and/or ODM agree to have, in a written agreement, the same restrictions, conditions, and requirements that apply to MCP with respect to the use or disclosure of PHI.

g. **Accessibility of Information.** The MCP must make available to ODM such information as ODM may require to fulfill its obligations to provide access to, provide a copy of any information or documents with respect to PHI pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 CFR 164.524 and 164.528 and any amendments thereto.

h. **Amendment of Information.** The MCP shall make any amendment(s) to PHI as directed by, or agreed to, by ODM pursuant to 45 CFR 164.526, or take other steps as necessary to satisfy ODM's obligations under 45 CFR 164.526. In the event that the MCP receives a request for amendment directly from an individual, agent, or subcontractor, the MCP must notify ODM prior to making any such amendment(s). The MCP's authority to amend information is explicitly limited to information created by the MCP.

i. **Accounting for Disclosure.** The MCP shall maintain and make available to ODM or individuals requesting the information as appropriate, records of all disclosures of PHI in a Designated Record Set as necessary to satisfy ODM's obligations under 45 CFR 164.528. For every disclosure, the record must include, at a minimum, the name of the individual who is the subject of the disclosure, the date of the disclosure, reason for the disclosure if any, and the name and address of the recipient to which the PHI was disclosed.

j. **Obligations of ODM.** When the MCP is required to carry out an obligation of ODM under Subpart E of 45 CFR Part 164, the MCP agrees to comply with all applicable requirements of Subpart E that would apply to ODM in the performance of such obligation.

k. **Access to Books and Records.** The MCP shall make available to ODM and to the Secretary of the U.S. Department of Health and Human Services any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from ODM, or created or received on behalf of ODM. Such access is for the purposes of determining compliance with the HIPAA Rules.

l. **Material Breach.** In the event of material breach of the MCP's obligations under this Article, ODM may immediately terminate this Agreement as set forth in ARTICLE VI, Section B. Termination of this Agreement will not affect any provision of this Agreement, which, by its wording or its nature, is intended to remain effective and to continue to operate after termination.

m. **Return or Destruction of Information.** Upon termination of this Agreement and at the request of ODM, the MCP will return to ODM or destroy all PHI in MCP's possession stemming from this Agreement as soon as possible but no later than 90 days, and will not keep copies of the PHI except as may be requested by ODM or required by law, or as otherwise allowed for under this Agreement. If the MCP, its agent(s), or subcontractor(s) destroy any PHI, then the MCP will provide to ODM documentation evidencing such destruction. Any PHI retained by the MCP will continue to be extended the same protections set forth in this Section, HIPAA regulations and this Agreement for as long as it is maintained.

n. **Survival**. These provisions shall survive the termination of this Agreement.

30. Electronic Communications

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

31. MCP Membership Acceptance, Documentation and Reconciliation

a. Medicaid Consumer Hotline Contractor - The MCP shall provide to the Hotline ODM prior-approved MCP materials and directories for distribution to eligible individuals who request additional information about the MCP.

b. Enrollment and Capitation Reconciliation

i. The MCP shall maintain the integrity of its membership data through reconciliation of the daily HIPAA 834C (Daily Benefit Enrollment and Maintenance File) and the monthly HIPAA 834F (Monthly Benefit Enrollment and Maintenance File) transactions. The monthly cycle is based on state cut-off dates (e.g., June 2012 enrollment reflects changes from that occurred April 19, 2012 – May 21, 2012). Please reference the Processing Dates for Calendar Year memo issued annually. Discrepancies between the HIPAA 834C and 834F that have a negative impact on a member's access to care must be reported to ODM within one (1) business day.

ii. The HIPAA 820 (Monthly Remittance Advice) will contain the following: a capitation payment for each member listed on the HIPAA 834F, a capitation payment/recoupment for changes listed in the daily HIPAA 834C, any other capitation payment/recoupment, and delivery payment/recoupment from the previous calendar month. Reconciliation for any discrepancies between the HIPAA 834 and HIPAA 820 is due and must be submitted, as instructed by ODM, no later than sixty (60) days after the issuance of the HIPAA 834F. Please reference the Processing Dates for Calendar Year memo that is issued annually. In the event of changes in the processing dates, the due date will be adjusted accordingly.

iii. All reconciliation requests must be submitted in the format specified by ODM. ODM may reject reconciliation requests that are submitted after the due date. Reconciliation requests submitted after the due date will be processed at the discretion of ODM. Recoupments, date of death, duplicative payments made to the same plan due to multiple IDs will always be processed.

c. Change in Enrollment During Hospital/Inpatient Facility Stay - When an MCP learns of a currently hospitalized member's intent to disenroll through the CCR or the HIPAA 834, 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 shall not request and/or require that a disenrolled member be discharged from the inpatient facility for transfer to another inpatient facility. Should a discharge and transfer to another inpatient facility be medically necessary, the disenrolling MCP must

notify the treating providers to work with the enrolling MCP or ODM as applicable to facilitate the discharge, transfer and authorization of services as needed.

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 shall contact the hospital/ inpatient facility. The enrolling MCP shall verify that it is responsible for all medically necessary Medicaid covered services from the effective date of MCP membership, including professional charges related to the inpatient stay; the enrolling MCP must inform the hospital/inpatient facility that the admitting/disenrolling MCP remains responsible for the hospital/inpatient facility charges through the date of discharge. The enrolling MCP shall work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.

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

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

e. Newborn Notifications – MCP membership for newborns will be in accordance with rule OAC 5160-26-02.

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

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

f. Eligible Individuals (pursuant to OAC 5160-26-01)- If an eligible individual contacts the MCP, the MCP must provide any MCP-specific managed care program information requested. The MCP must not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/transitioning health care services, the MCP shall provide an assurance that all MCPs must cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.

g. Pending Member - 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 must provide any membership information requested, including but not limited to explaining how to access services as an MCP member and assistance in determining whether current services require prior authorization. The MCP must also ensure that any care coordination (e.g., PCP selection, prescheduled services and transition of services) information provided by the pending member is logged in the MCP's system and forwarded to the appropriate MCP staff for processing as required.

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

32. The MCP must use ODM-provided utilization and prior authorization data files for care coordination/management activities and to adhere to transition of care requirements.

33. Transition of Fee-For-Service (FFS) Members

Providing care coordination for prescheduled health services, access to preventive and specialized care, care management, member services, and education with minimal disruption to members' established relationships with providers and existing care treatment plans, is critical for members transitioning from FFS to managed care. The MCP is not required to continue services identified in 33.b and 33.c of this Appendix for a member who resides in a service area in which enrollment in an MCP is not required and the member voluntarily chooses to enroll in the MCP.

a. ABD Member Transition Plan - For FFS members who are transitioning to managed care as ABD members, and for members under 21 with an SSI indicator, the MCP must develop and implement transition plans that outline how the MCP will effectively address the unique care coordination issues of members in their first three months of MCP membership and how the various MCP departments will coordinate and share information

regarding these new members. The transition plan must include at a minimum:

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

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

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

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

ii. Strategies for how each new member will obtain care therapies from appropriate sources of care as an MCP member. The MCP's strategies must include at a minimum activities specified in 33.b of this Appendix, as applicable.

b. Member Continuation of Services - The MCP must allow a new member who is transitioning from FFS to an MCP to receive services from network and out-of-panel providers, if any of the following applies:

i. The CFC or Adult Extension member has appointments within the initial month of MCP membership with specialty physicians that were scheduled prior to the effective date;

ii. The ABD member 21 years or older has appointments within the initial three months of MCP membership with a primary care provider or specialty physician that were scheduled prior to the effective date of membership; or the ABD member under age 21 or member under 21 with an SSI indicator, may continue with out-of-network physician services for up to 180 days after the date of MCP enrollment unless the MCP has identified the member's need for care management by the

process specified in Appendix K.2.h. An identified need for care management for the ABD member under age 21 or member under 21 with an SSI indicator authorizes the MCP to require members to use participating physicians so that care and services can be coordinated by the MCP, after a period of 90 days after the date of MCP enrollment;

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

iv. The member has been scheduled for an inpatient or outpatient surgery and has been prior-approved and/or pre-certified pursuant to OAC rule OAC rule 5160-2-40 (surgical procedures would also include follow-up care as appropriate);

v. The member is receiving ongoing chemotherapy or radiation treatment; or

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

vii. The member is an Adult Extension member and is receiving care in a nursing facility on the effective date of enrollment with the MCP. Upon confirming this, the MCP must cover nursing facility care to be provided at the same facility until a medical necessity review has been completed and a transition to an alternative placement has been documented in the member's care plan.

c. Member Continuation of Home Care and Private Duty Nursing (PDN) Services - The MCP must allow its new members that are transitioning from FFS to continue receiving home care services (i.e., nursing, aide, and skilled therapy services) and PDN services. These services must be covered at the current service level, and with the current provider, regardless of whether the current provider is a panel or out-of-panel provider, until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule OAC rule 5160-26-03.1. As soon as the MCP becomes aware of the member's current home care or PDN services, the MCP must initiate contact with the current provider and member as applicable to ensure continuity of care and coordinate a transfer of services to a panel provider, if appropriate.

For ABD members under 21 years of age and for members under 21 with

an SSI indicator, the MCP must allow continuation of home care services provided pursuant to OAC rule 5160-12-01 at the existing service level with the current home health agency provider for a period of 90 days after initial MCP enrollment. After 90 days of enrollment, prior to requiring transition to a participating provider or proposing a change in the service amount, the MCP must make a home visit, and observe the home care service being provided, to assess the need for continued home care services.

For ABD members under 21 years of age and for members under 21 with an SSI indicator, the MCP must allow continuation of PDN services provided pursuant to OAC rule 5160-12-02 at the existing service level with the current provider for a period of 90 days after initial MCP enrollment. After 90 days of enrollment, prior to requiring transition to a participating provider, or proposing a change in the service amount or termination or reduction of the FFS authorized service amount, the MCP must make a home visit, and observe the PDN services being provided, to assess the need for continued PDN services.

d. Member FFS Authorizations – The MCP must honor any current FFS prior authorization to allow its new members that are transitioning from FFS to receive services from the authorized provider, regardless of whether the authorized provider is a panel or out-of-panel provider, for the following approved services:

i. An organ, bone marrow, or hematopoietic stem cell transplant pursuant to OAC rule 5160-2-07.1 and 2.b.vii of Appendix G;

ii. Dental services that have not yet been received;

iii. Vision services that have not yet been received;

iv. Durable medical equipment (DME) that has not yet been received. Ongoing DME services and supplies are to be covered by the MCP as previously authorized until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.

v. Private Duty Nursing (PDN) services. Except for ABD members under 21 years of age and those under 21 with an SSI indicator, PDN services must be covered at the previously-authorized service level until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.

As soon as the MCP becomes aware of the member's current FFS authorization approval, the MCP must initiate contact with the authorized provider and member as applicable to ensure continuity of care. The MCP must implement a plan to meet the member's immediate and ongoing medical needs and coordinate the transfer of services to a panel provider, if appropriate.

For organ, bone marrow or hematopoietic stem cell transplants, MCPs must receive prior approval from ODM to transfer services to a panel provider.

When an MCP medical necessity review results in a decision to reduce, suspend, or terminate services previously authorized by FFS Medicaid, the MCP must notify the member of his or her state hearing rights no less than 15 calendar days prior to the effective date of the MCP's proposed action, per OAC rule 5160-26-08.4.

e. Out-of-Panel Provider Reimbursement – The MCP must reimburse out-of-panel providers that agree to provide the transition services at 100% of the current Medicaid FFS provider rate for the service(s) identified in 33 (b, c, and d) of this Appendix.

f. Documentation of services – The MCP must document the provision of transition of services identified in 33 (b, c, and d) of this Appendix as follows:

i. The MCP must provide notification to non-panel providers confirming the provider's agreement or disagreement to provide the service and accept 100% of the current Medicaid FFS rate as payment. If the provider agrees, the MCP shall distribute its materials to the non-panel provider as outlined in Appendix G.3 of this Agreement.

ii. If the non-panel provider does not agree to provide the service, the MCP must notify the member of the MCP's availability to assist with locating a provider as expeditiously as the member's health condition warrants.

iii. If the service will be provided by a panel provider, the MCP must notify the panel provider and the member to confirm the MCP's responsibility to cover the service.

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

g. Member Transition of Care for Prescription Drugs
The MCP is responsible for implementing transition of care processes that prevent access problems for members that are transitioning from the FFS pharmacy benefit administrator to an MCP. The transition of care processes must be prior approved by ODM and at a minimum include the following:

i. The MCP may not require prior authorization (PA) of prescriptions filled according to paragraph ii. below, until the MCP has educated the member that further administration will require the prescribing provider to request PA and, if applicable, the option of using an alternative medication that may be available without PA. Written member education notices must use ODM-specified model language. Verbal member education may be done in place of written education but must contain the same information as a written notice. MCP member notices and call scripts must be prior approved by ODM.

ii. For new members who transition from FFS to an MCP, the MCP may not require PA in the first month of membership, for at least one prescription refill for claims approved by Ohio Medicaid during the prior FFS enrollment period.

iii. For antidepressant and antipsychotic medications, the MCP must abide by the restrictions on PA described in Appendix G.2.b.vi of this Agreement.

34. Transition of Care Requirements for Members of an Exiting MCP

When the enrolling MCP is informed by ODM, or its designee, of a member transitioning from the exiting MCP, the enrolling MCP must follow the transition of care requirements as set forth in Appendix C.33, above.

35. Health Information System Requirements

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

a. Health Information System

i. As required by 42 CFR 438.242(a), the MCP must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and MCP membership terminations for other than loss of Medicaid eligibility.

ii. As required by 42 CFR 438.242(b)(1), the MCP must collect data on member and provider characteristics and on services furnished to its members.

iii. As required by 42 CFR 438.242(b)(2), the MCP must ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic, and consistency, and collecting service information in standardized formats to the extent feasible and appropriate.

iv. As required by 42 CFR 438.242(b)(3), the MCP must make all collected data available upon request by ODM or CMS.

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

a. Before the MCP may submit production files;

b. Whenever the MCP changes the method or preparer of the electronic media; and/or

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

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

Submission of test files can start before the new or modified information system <u>is</u> in production. ODM reserves the right to verify any MCP's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period. Penalties for noncompliance with this requirement are specified in Appendix N of this Agreement, *Compliance Assessment System*.

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

(i) Claims Adjudication

The MCP must have the capacity to electronically accept and adjudicate all claims to final status (payment or denial). Information on claims submission procedures must be provided to non-contracting providers within thirty (30) days of a request. The MCP must inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information must be initiated by the MCP and not only in response to provider requests.

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

(ii) The MCP is prohibited from recovering back or adjusting any payments that are beyond two years from the date of payment of the claim due to the MCP member's retroactive termination of coverage from the MCP, unless the MCP is directed to do so by CMS, ODM, or applicable state or federal law and regulation. However, the preceding sentence does not prohibit the MCP or ODM from initiating a recovery or adjustment more than two years after the payment of a claim in the event of fraud, abuse, or as otherwise provided by applicable state or federal law and regulation.

(iii) The MCP must have policies providing that, upon discovery of claims payment systemic errors that resulted in incorrectly underpaying or denying claims, the MCP is required to reprocess and correctly pay such claims, from the date of identification of the error retroactively through the period specified in the contract between the MCP and the provider for claims payment corrective activity. A claims payment systemic error is defined as involving more than five providers, or involving a significant number of payment errors if five or fewer providers are affected. If a claims payment systemic error occurs, the MCP shall notify ODM of the error and shall specify its process and timeline for corrective action, unless the MCP corrects the payments within 60 days from the date of identification of the error. The MCP's policies must include how corrective action will be taken on behalf of all affected providers, regardless of whether the claims payment systemic error is identified by the MCP or by any provider. If the error is not a claims payment systemic error, the MCP shall correct the payments within 60 days from the date of identification of the error.

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

(v) Electronic Data Interchange
The MCP shall comply with all applicable provisions of HIPAA including electronic data interchange (EDI) standards for code sets and the following electronic transactions:
Health care claims;
Health care claim status request and response;
Health care payment and remittance status;
Standard code sets; and
National Provider Identifier (NPI).

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

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

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

ASC X12 834 - Benefit Enrollment and Maintenance.

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

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

(vii) Verification of Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996)
MCPs shall comply with the transaction standards and code sets for sending and receiving applicable transactions as specified in 45 CFR Part 162 (HIPAA regulations). In addition the MCP must enter into the appropriate trading partner agreement and implemented standard code sets. If the MCP has obtained third-party certification of HIPAA compliance for any of the items listed below, that certification may be submitted in lieu of the MCP's written verification for the applicable item(s).

i. Trading Partner Agreements
ii. Code Sets
iii. Transactions

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

(viii) Trading Partner Agreement with ODM
MCPs must complete and submit an EDI trading partner agreement in a format specified by ODM. Submission of the copy of the trading partner agreement prior to entering into this Agreement may be waived at the discretion of ODM; if submission prior to entering into this Agreement is waived, the trading partner agreement must be submitted at a subsequent date determined by ODM.

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

c. Encounter Data Submission Requirements

General Requirements

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

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

Acceptance testing of encounter data is required as specified in 35.a.v. of this Appendix.

Encounter Data File Submission Procedures

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

d. IDSS Data Submission and Audit Report Requirements

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

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

e. Information Systems Review

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

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

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

ii. Review the completed ISCA and accompanying documents;

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

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

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

vi. Examine MCP processes for data transfers;

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

viii. Review MCP processes, documentation, and data files to ensure that they comply with state specifications for encounter data submissions; and

ix. Assess the claims adjudication process and capabilities of the MCP.

36. Delivery (Childbirth) Payments – CFC and Adult Extension Members Only

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

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

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

If a physician and a hospital encounter are found for the same delivery, only one payment will be made. The same is true for multiple births; if multiple delivery encounters are submitted, only one payment will be made.

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

Timing of Delivery Payments
The MCP will be paid monthly for deliveries. For example, payment for a delivery encounter submitted with the required encounter data submission in March, will be reimbursed in May.

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

Updating and Deleting Delivery Encounters
The process for updating and deleting delivery encounters can be found in the Covered Families and Children (CFC) Delivery Payment Reporting Procedures and Specifications for ODM Managed Care Plans (MITS version - draft) document.

Auditing of Delivery Payments
A delivery payment audit will be conducted periodically. If medical records do not substantiate that a delivery (at least 22 weeks gestation) occurred related to the payment that was made, then ODM will recoup the delivery payment from the MCP. Also, if it is determined that the encounter which triggered the delivery payment was not a paid encounter, then ODM will recoup the delivery payment.

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

38. The MCP must receive prior written approval from ODM before adding any information to its website that would require ODM prior approval in hard copy form (e.g., provider listings, member handbook information).

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

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

41. Information Required for MCP Websites

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

b. On-line Member Website – The MCP must have a secure internet-based website which provides members the ability to submit questions, comments, grievances, and appeals, and receive a response. Members must be given the option of a response by return e-mail or phone call. The MCP's responses to questions or comments must be made within one working day of receipt. The MCP's responses to grievances and appeals must adhere to the timeframes specified in OAC rule 5160-26-08.4. The member website must be regularly updated to include the most current ODM-approved materials, although this website must not be the only means for notifying members of new and/or revised MCP information (e.g., change in holiday closures, changes in additional benefits, and revisions to approved member materials). The MCP must make a copy of its Authorized Representative request form available to members through its online member portal located on the MCP's website.

The MCP member website must also include, at a minimum, the following information which must be accessible to members and the general public without any log-in restriction: (1) MCP contact information, including the MCP's toll-free member services phone number, service hours, and closure dates; (2) a listing of the counties the MCP serves unless the MCP serves the entire state in which case the MCP may indicate it services the entire states; (3) the ODM-approved MCP member handbook, recent newsletters and announcements; (4) the MCP's on-line provider directory as referenced in section 41.a. of this appendix; (5) a list of services requiring PA; (6) the MCP's preferred drug list (PDL), including an explanation of the list and identification of any 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; (7) the toll-free telephone number for the 24/7 medical advice call-in system specified in OAC rule 5160-26-03.1 (A) (6); and (8) contact information to schedule non-emergency transportation assistance, including an explanation of the available services and how to contact member services for transportation services complaints. The MCP must publish a thirty (30) days advance notice of changes to

the MCP list of drugs requiring prior authorization via their website. 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. ODM may require the MCP to include additional information on the member website as needed.

Provide all Healthchek information as specified in 25.a.i. of this Appendix.

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

The MCP provider website must also include, at a minimum, the following information which must be accessible to providers and the general public without any log-in restrictions: (1) MCP contact information, including the MCP's designated contact for provider issues; (2) a listing of the counties the MCP serves unless the MCP serves the entire state in which case the MCP may indicate it services the entire states; (3) the MCP's provider manual including the MCP's claims submission process, as well as a list of services requiring PA, recent newsletters and announcements; (4) the MCP's policies and procedures for out-of-network providers to seek payment of claims for emergency, post-stabilization and any other services authorized by the MCP; (5) the MCP's on-line provider directory as referenced in section 41.a. of this appendix; and (6) the MCP's PDL, including an explanation of the list and identification of any 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 MCP must publish a thirty (30) days advance notice of changes to the MCP list of drugs requiring prior authorization via their website. ODM may require the MCP to include additional information on the provider website as needed.

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

Provide all Healthchek information as specified in 25.b.i. of this Appendix.

42. The MCP must provide members with a printed version of its Preferred Drug List (PDL) and Prior Authorization (PA) lists upon request.

43. PCP Feedback – The MCP must have the administrative capacity to offer feedback to individual providers on their: 1) adherence to evidence-based practice guidelines; and

2) positive and negative care variances from standard clinical pathways that may impact outcomes or costs. In addition, the feedback information may be used by the MCP for activities such as provider performance improvement projects that include incentive programs or the development of quality improvement programs.

44. Coordination of Benefits - When a claim is denied due to third party liability, the MCP must timely share appropriate and available information regarding the third party to the provider for the purposes of coordination of benefits, including, but not limited to third party liability information received from ODM.

45. MCP Submission Due Dates - Unless otherwise indicated, MCP submissions with due dates that fall on a weekend or holiday are due the next business day.

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

47. The MCP must subscribe to the appropriate distribution lists for notification of all 1) OAC rule clearances, and 2) final rules published with medical assistance letters (MALs), Medicaid handbook transmittal letters (MHTLs), and other transmittal letters affecting managed care program requirements. The MCP is solely responsible for submitting its names and email addresses to the appropriate distribution lists and is also responsible for ensuring the validity of any e-mail addresses maintained on those distribution lists.

48. Transfer of Protected Health Information from ODM Fee-For-Service Pharmacy Benefit Manager

ODM contracts with ACS to serve as the pharmacy benefits manager for ODM ("the PBM Agreement") with respect to the management, provision and payment of pharmacy benefits for Ohio Medicaid fee-for-service consumers.

In order to compile, analyze, prepare and file HEDIS reports and to assess on-going health care needs, MCPs require certain ongoing data related to pharmacy benefits provided under the PBM Agreement. ODM has instructed ACS to provide the data to the MCPs. The data to be transferred includes Protected Health Information (PHI) as defined in 45 C.F.R. Parts 160 and 164 (Privacy Regulations").

ODM and the MCP are covered entities under the Health Insurance Portability and Accountability Act of 1996, and ODM asserts that both ACS and MCP are Business Associates of ODM, as defined in the Privacy Regulations, and each of ACS and MCP

has executed a Business Associate Agreement directly with ODM in accordance with the Health Insurance Portability and Accountability Act of 1996 and the Privacy Regulations.

Data shall be transferred in electronic format and is limited to the data fields set forth in the data transfer document that was jointly developed by ODM, ACS, and the MCPs. ACS shall transfer such information for a period of time necessary for the MCP to meet its contractual duties under this agreement. ODM represent and warrants that separate from this Provider Agreement, a Business Associate agreement that complies fully with the Health Insurance Portability and Accountability Act of 1996 and the HITECH provisions of the American Recovery and Reinvestment Act of 2009 (collectively "HIPAA") and with 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations") has been executed by ACS and is currently effective, and will remain in effect for the Term of this Agreement.

ACS will automatically delete any file that is older than 30 days (i.e. 31 calendar days or more backwards in time) from their FTP pick-up site. MCPs must reimburse ACS to recreate a file that has been moved and/or automatically deleted from the ACS FTP pick-up site. While the cost to recreate a file will be based on technical human resources, development, and processing time; the maximum cost ACS will charge MCPs to recreate a file will be $1,000 per file.

49. Pursuant to O.R.C. 5167.14, MCPs must enter into a data security agreement with the State of Ohio's Board of Pharmacy that governs the MCP's use of the Board's drug database established and maintained under O.R.C. 4729.75.

50. Upon request by ODM, the MCP must share data with ODM's actuary, Mercer. ODM and the MCP are covered entities under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). ODM represents and warrants that separate from this Provider Agreement, a Business Associate agreement that complies fully with HIPAA and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the implementing federal regulations under both Acts, has been executed by Mercer, is currently in effect, and will remain in effect for the Term of this Agreement.

51. As outlined in OAC rule 5160-26-05(D), MCP subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).

52. The MCP must comply with Executive Order 2011-12K. A copy of Executive Order 2011-12K can be found at http://governor.ohio.gov/MediaRoom/ExecutiveOrders.aspx. This Executive Order prohibits the use of public funds to purchase services that will be provided outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. Additionally, the MCP must not transfer PHI to any location outside the United States or its territories.

53. The MCP 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 MCP must achieve and/or maintain an Excellent, Commendable or Accredited status. If the MCP receives a Provisional or Denied status from NCQA, the MCP will be subject to sanctions as noted in Appendix N. Compliance will be assessed annually based on the MCP's accreditation status as of September 15th of each year.

For the purposes of meeting this accreditation requirement, ODM will only accept the use of the NCQA Corporate Survey Process to the extent deemed allowable by NCQA.

Upon completion of the accreditation survey, the MCP must submit to ODM a copy of the "Final Decision Letter" no later than 10 calendar days upon receipt from NCQA. Thereafter and on an annual basis between accreditation surveys, the MCP must submit a copy of the "Accreditation Summary Report" issued as a result of the Annual HEDIS Update no later than 10 calendar days upon receipt from NCQA. Upon ODM's request, the MCP must provide any and all documents related to achieving accreditation.

54. Pursuant to Section 1202 of the Health Care and Education Reform Act of 2010, and final Federal regulations that took effect January 1, 2013, 42 C.F.R. 438.6 and 438.804, MCPs are required and agree herein to pay qualified primary care providers the lower of the provider's actual billed charge or the Medicare rates specified by ODM for calendar years 2013 and 2014 for the following services:

(a) Evaluation and Management (E & M) codes 99201 through 99499 except the following:

99288	99339	99340	99354	99355	99356	99357	99358
99359	99360	99363	99364	99366	99367	99368	99374
99375	99377	99378	99379	99380	99386	99387	99396
99397	99401	99408	99409	99411	99412	99420	99429
99441	99442	99443	99444	99450	99455	99456	99499

and (b) Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474, and their successor codes. The administration of Vaccines for Children program vaccines will be reimbursed at the allowable regional maximum rate. All other vaccine administrations will be reimbursed using the same methodology as the E & M codes.

The MCP certifies that each qualified primary care physician receives the full benefit of the enhanced payment at the lower of the physician's actual billed charge or the Medicare rates, specified by ODM, for each eligible primary care service rendered during the term of this Agreement. This requirement and certification of the MCP hereunder applies even when the

MCP's contract is with a group practice or other entity in which not all physicians qualify for the enhanced payments.

The enhanced payment requirement is effective retrospective to the provider's effective date of eligibility for the increase as determined by ODM and provided to the MCP. The enhanced payment requirement applies to all units rendered by a qualified primary care physician billed using a qualified billing code as of the effective date of the provider's eligibility. The MCP must make increased payments to qualifying providers no less than quarterly.
The MCP agrees to provide sufficient documentation to ODM, as required by ODM and CMS, to implement these requirements. The MCP agrees to accept reimbursement for the primary care physician rate increase and vaccine administration rate increase based on the CMS-approved payment methodology outside capitation payments.

ODM agrees to reimburse the MCP, and the MCP agrees to accept, for qualifying primary care physician services, the required minimum Medicare payment amounts calculated by ODM for the primary care physician rate increase and vaccine administration rate increase. Payments will consist of actuarially sound capitation rates. In addition, ODM and the MCP agree to accept the results of an annual reconciliation, pursuant to the applicable CMS-approved payment methodology.

55. <u>MCP Family Advisory Council</u>

The MCP must convene an MCP Family Advisory Council at least quarterly in each region that the MCP serves consisting of the MCP's current members. The purpose of the Council is to engage members in such a way as to elicit meaningful input related to the MCP's strengths and challenges with respect to serving members. The composition of the group must be diverse and representative of the MCP's current membership throughout the region with respect to the members' race, ethnic background, primary language, age, Medicaid eligibility category (Adult Extension, CFC and ABD), and health status.

The MCP must report the following to ODM on or before the 15th of July, October, January and April of each calendar year:

- A list of attending members during the prior quarter for each regional Advisory Council;
- Meeting dates, agenda and the minutes from each regional meeting that occurred during the prior quarter; and
- Improvement recommendations developed by each Council.

56. MCP must participate in the development, implementation, and operation of initiatives for early managed care enrollment and care coordination for inmates to be released from state prisons or state psychiatric hospitals and youths in Department of Youth Services custody.

57. If the MCP uses a Diagnosis Related Grouper (DRG) to pay for inpatient hospital claims, then the MCP must use the All-Patient Refined (APR) DRG that is the same version that ODM uses.
58. The MCP is prohibited from paying for nursing facility services during a restricted Medicaid coverage period (RMCP).

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

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

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

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

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

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

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

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

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

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

This provision shall survive the termination of the Agreement.

60. Hepatitis C Risk Pool Arrangement

Pursuant to the Hepatitis C Risk Pool Arrangement described in Appendix E, Rate Methodology, MCPs must participate in a Hepatitis C risk pool arrangement during calendar year (CY) 2015. The amount of the risk pool is determined by the projected Hepatitis C costs incorporated into the CY 2015 rates. ODM will redistribute funds among MCPs based on the actual Hepatitis C costs. This risk pool will be used to account for any MCP(s) getting a disproportionate share of members using Hepatitis C drugs by giving plans that experience adverse selection or relatively adverse claims experience a greater proportion of the risk pool funds.

61. Comprehensive Disaster/Emergency Response Planning

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

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

The MCP must participate in ODM sanctioned workgroups and processes to establish a state-level emergency response plan which will include a provision for Medicaid consumers, and will comply with the resulting procedures.

During the time of an emergency or a natural, technological, or man-made disaster, the MCP must be able to generate a current list of members for whom an individual disaster plan, according to the specifications below, has been developed, including the risk and the individual-level plan, and distribute to local and state emergency management authorities according to the protocol established by ODM.

Individual Disaster/Emergency Response Plan

The MCP must identify members who are at risk for harm, loss, or injury during any potential natural, technological, or manmade disaster. The MCP must assure that every member who is technology and/or service dependent, with no known reasonable means to access services, is known and documented as part of the plan's Comprehensive Disaster/Emergency Response Plan. For these members, the MCP must develop an individual-level plan with the member if appropriate. The member-level plan must: 1) include a provision for the continuation of critical services appropriate for the member's needs in the event of a disaster including, but not limited to access to medication/prescriptions; 2) identify how and when the plan will be activated; 3) be documented in the member record maintained by the MCP; and 4) be provided to the member.

The MCP must ensure that staff, including care managers, are prepared to respond to and implement the plans in the event of an emergency or disaster.

62. ICD-10 Implementation

MCP shall be responsible for meeting all ICD-10 requirements, as required by ODM. The MCP shall be responsible for meeting all 5010 transaction changes, ICD-10 code set changes and required testing with ODM.

APPENDIX D

ODM RESPONSIBILITIES

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

General Provisions

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

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

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

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

5. ODM will provide MCP's linkages to organization that can provide guidance on the development of effective strategies to eliminate health disparities.

6. ODM will conduct an annual analysis of Medicaid eligible individuals to identify whether there are any prevalent common primary languages, other than English, in the MCP service areas. ODM will notify the MCP of any languages that are identified as prevalent for the purpose of translating marketing and member materials (See Appendix C.22).

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

8. ODM will identify contact staff, including the Contract Administrator (CA), selected for each MCP.

9. ODM will provide MCPs with an electronic Provider Master File containing all the Ohio Medicaid fee-for-service (FFS) providers, which includes their Medicaid Provider Number, as well as all providers who have been assigned a provider reporting number for current encounter data purposes. This file also includes NPI information when available.

10. Service Area Designation

ODM will implement a mandatory managed care program in service areas wherever choice and capacity allow and the criteria in 42 CFR 438.50(a) are met.

11. Consumer Information

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

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

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

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

12. Membership Selection and Premium Payment

a. The Medicaid Consumer Hotline (henceforth referred to as the "Hotline") - The ODM-contracted Hotline is responsible for providing unbiased education and selection services for the Medicaid managed care program. The Hotline operates a statewide toll-free telephone center to assist eligible individuals in selecting an MCP or choosing a health care delivery option.

b. Auto-Assignment Eligible individuals that fail to select a plan will be assigned to an MCP in accordance with 42 CFR 438.50 and at the discretion of ODM.

c. Consumer Contact Record (CCR): ODM or their designated entity shall provide CCRs to MCPs on no less than a weekly basis. The CCRs are a record of each consumer initiated MCP enrollment, change, or termination, and each Hotline initiated MCP assignment processed through the Hotline.

d. ODM verifies MCP enrollment via a membership roster. ODM or its designated entity provides a full member roster (F) and a change roster (C) via HIPAA 834 compliant transactions.

e. Monthly Premiums - ODM will remit payment to the MCPs via an electronic funds

transfer (EFT), or at the discretion of ODM, by paper warrant.

f. Remittance Advice (RA) - ODM will confirm all premium payments paid to the MCP during the month via a monthly RA. ODM or its designated entity will provide a record of each recipient detail level payment via HIPAA 820 compliant transactions. ODM or its designee will keep a record of each MCPs Accounts Payable (i.e. Pay 4 Performance, Primary Care Rate Increase, and Health Insurance Provider Fee) and Accounts Receivable (i.e. PCRI Reconciliation, Penalty, Credit Balance) transaction on the MITS Provider Portal Report Tab.

13. ODM will make available a website which includes current program information.

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

15. Communications - The Bureau of Managed Care (BMC) is responsible for the oversight of the MCPs' provider agreements with ODM. Within the BMC, a specific Contract Administrator (CA) has been assigned to each MCP. Unless expressly directed otherwise, MCPs shall first contact their designated CA for questions/assistance related to Medicaid and/or the MCP's program requirements /responsibilities. If their CA is not available and the MCP needs immediate assistance, MCP staff should request to speak to a supervisor within the Managed Care Contract Administration Section.

APPENDIX E

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October 28, 2014

Subject: Calendar Year 2015 Capitation Rate Certification — Aged, Blind, or Disabled Children

Dear Ms. Ghatak:

The State of Ohio (State) Department of Medicaid (ODM) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rates[1] for the calendar year (CY) 2015 Aged, Blind, or Disabled Children (ABD <21) Risk-Based Managed Care program. This letter provides a certification of the resulting ABD <21 rates.

Enclosures

Accompanying this letter are the following enclosures:

1. Managed Care Plan (MCP) Rate Structure.
2. Historical (Base) Data Development.
3. Projected Cost Development.
4. Adjustments to Reflect an Efficient Managed Care Environment.
5. Risk-Adjustment Applications.

Rate Certification

In preparing the capitation rates for the CY 2015 ABD <21 Risk-Based Managed Care program, Mercer has used and relied upon enrollment, eligibility, claim, encounter, and other information supplied by the State and its vendors. The State and its vendors are responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the data and information for internal consistency and reasonableness, but Mercer did not audit it. If the data and information is incomplete or inaccurate, the values shown in this letter may need to be revised accordingly.

[1] Mercer defines the term “actuarially sound” within the rate certification section of the letter.

Mercer certifies that the rates were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify the actuarial soundness[2] of Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. Actual costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the Centers for Medicare and Medicaid Services (CMS) requirements under 42 CFR 438.6(c) and in accordance with applicable laws and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

MCPs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by MCPs for any purpose. Mercer recommends that any MCP considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the Ohio Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. It is intended for the State and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. This document should only be reviewed in its entirety.

[2] Medicaid benefit plan premium rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8–9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/files/publications/Practice_Note_Actuarial_Certification_Rates_for_Medicaid_Managed_Care_Programs_aug2005.pdf

If you have any questions on any of the above, please feel free to contact Mike Nordstrom at +1 602 522 6510 or Ernest Jaramillo at +1 602 522 6444.

Sincerely,

Mike Nordstrom, ASA, MAAA
Partner

Ernest Jaramillo, ASA, MAAA
Senior Associate

MN/EJ/mb

Enclosures

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October 28, 2014

Subject: Calendar Year 2015 Capitation Rate Certification — Covered Families and Children and Aged, Blind, or Disabled Adults

Dear Ms. Ghatak:

The State of Ohio (State) Department of Medicaid (ODM) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rates[1] for calendar year (CY) 2015 for the Covered Families and Children (CFC) and Aged, Blind, or Disabled Adults (ABD 21+) Risk-Based Managed Care program. This letter provides a certification of the resulting CFC and ABD 21+ rates.

Enclosures

Accompanying this letter are the following enclosures:

1. Managed Care Plan (MCP) Rate Structure.
2. Historical (Base) Data Development.
3. Projected Cost Development.
4. Adjustments to Reflect an Efficient Managed Care Environment.
5. Risk-Adjustment Applications.

Rate Certification

In preparing the capitation rates for the CY 2015 CFC and ABD 21+ Risk-Based Managed Care program, Mercer has used and relied upon enrollment, eligibility, claim, encounter, financial and other information supplied by the State and its vendors. The State and its vendors are responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the data and information for internal consistency and reasonableness, but Mercer did not audit it. If the

[1] Mercer defines the term “actuarially sound” within the rate certification section of the letter.

data and information is incomplete or inaccurate, the values shown in this letter may need to be revised accordingly.
Mercer certifies that the rates were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify the actuarial soundness[2] of Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. Actual costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the Centers for Medicare and Medicaid Services (CMS) requirements under 42 CFR 438.6(c) and in accordance with applicable laws and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

MCPs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by MCPs for any purpose. Mercer recommends that any MCP considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the Ohio Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. It is intended for the State and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. This document should only be reviewed in its entirety.

[2] Medicaid benefit plan premium rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8–9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/files/publications/Practice_Note_Actuarial_Certification_Rates_for_Medicaid_Managed_Care_Programs_aug2005.pdf

If you have any questions on any of the above, please feel free to contact Mike Nordstrom at +1 602 522 6510 or Ernest Jaramillo at +1 602 522 6444.

Sincerely,

Mike Nordstrom, ASA, MAAA
Partner

Ernest Jaramillo, ASA, MAAA
Senior Associate

MN/EJ/mb

Enclosures

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Ms. Mitali Ghatak
Ohio Department of Medicaid
Bureau of Managed Health Care
Lazarus Building
50 West Town Street, Suite 400
Columbus, OH 43215

October 28, 2014

Subject: Calendar Year 2015 Capitation Rate Certification — Extension

Dear Ms. Ghatak:

The State of Ohio (State) Department of Medicaid (ODM) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rates[1] for the calendar year (CY) 2015 Extension population that will receive services through managed care plans (MCPs). The Extension population covers Parents from 91% to 138% (includes the 5% income disregard) of federal poverty level (FPL) and Childless Adults from 0% to 138% of FPL. This letter provides a certification of the resulting Extension rates.

Enclosures

Accompanying this letter are the following enclosures:

1. MCP Rate Structure.
2. Projected Medical Cost (Base) Data Development.
3. Adjustments to Reflect an Efficient Managed Care Environment.
4. Risk-Adjustment Applications.

Rate Certification

In preparing the capitation rates for the CY 2015 Extension Risk-Based Managed Care program, Mercer has used and relied upon enrollment, eligibility, claim, encounter, financial and other data, and information supplied by the State and its vendors. The State and its vendors are responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the data and information for internal consistency and reasonableness, but Mercer did not audit it. If the

[1] Mercer defines the term “actuarially sound” within the rate certification section of the letter.

data and information is incomplete or inaccurate, the values shown in this letter may need to be revised accordingly.
Mercer certifies that the rates were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify the actuarial soundness[2] of Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. Actual costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the Centers for Medicare and Medicaid Services (CMS) requirements under 42 CFR 438.6(c) and in accordance with applicable laws and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

MCPs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by MCPs for any purpose. Mercer recommends that any MCP considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the Ohio Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. It is intended for the State and CMS and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. This document should only be reviewed in its entirety.

[2] Medicaid benefit plan premium rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8–9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/files/publications/Practice_Note_Actuarial_Certification_Rates_for_Medicaid_Managed_Care_Programs_aug2005.pdf

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ENCLOSURE 1

MCP Rate Structure

The State and Mercer considered the potential risk variation of various subpopulations, along with the ease of operationalization, when determining the MCP rate structure. This section describes the rate group structure for the MCP programs.

Regions

For CY 2015, the MCP programs will operate in seven rating regions as outlined below:

Table 1.1 — Rating Regions

Region	Rating Region
West	A1 — North Central
	A2 — Northwest
	A3 — Southwest
Central/Southeast	B1 — South Central
	B2 — Southeast
Northeast	C1 — Northeast
	C2 — Northeast Central

Rate Groups

For CY 2015, base capitation rates were developed by rating region for ABD <21. These rates will be risk adjusted to account for variations in health risk among the MCPs. This process is described in greater detail in Enclosure 5.

ENCLOSURE 2

Historical (Base) Data Development

This section of the narrative describes the formation of the base data used to produce the databook and the following adjustments that were applied to produce the base data for rate development, which were applied after the release of the databook:

- Removal of Retro and Back-Dated Periods.
- Disproportionate Share Hospital (DSH) Payments.
- Graduate Medical Education (GME) Payments.
- Adjustment for Third Party Liability (TPL) and Fraud and Abuse (FA).
- Completion for Additional Claims Run Out.
- Application of Historical Program Changes.

Base Data Construction/Databook Preparation

The base data is comprised of CY 2012 fee-for-service (FFS) claims for the eligible ABD <21 population, excluding institutionalized, waiver, spend-down, Medicare dual eligibles, and long-term nursing facility (NF) recipients. Long-term NF was defined as stays lasting past the last day of the month following the admission to the NF. The eligibility population was limited to those eligible to enroll into the managed care program. Adjustments were also made to the base data to account for known eligibility issues present in CY 2012. In addition to these population exclusions, those services that will remain in FFS were excluded from the rate base.

Removal of Retro and Back-Dated Periods

In order to ensure that the capitation rates reflect the prospective risk, it was necessary to remove eligibility spans and claim dollars for periods that would not otherwise be eligible for managed care enrollment. Mercer subsequently analyzed the CY 2009 and CY 2010 proportion of eligibility months and claims dollars, as a percent of total, which were previously excluded from the data.

DSH Payments

The inpatient and outpatient FFS data used as the basis for rate setting does not include DSH payments. As a result, no adjustment was necessary to ensure that the rates are exclusive of the DSH payments hospitals will receive outside the capitation rates.

GME Payments

The inpatient FFS data used as the basis for rate setting includes GME payments, which is consistent with the approach that inpatient payments made by the MCPs account for the GME payments that are made to select hospitals. As a result, the rates include these payments within inpatient services.

Adjustment for TPL and FA

Mercer reviewed previously submitted CMS 64 reports to estimate the proportion of FFS claims that were historically recovered as TPL or FA.

Completion for Additional Claims Run Out

The base data includes claims incurred during CY 2012 and paid through June 2013. Mercer analyzed the completeness by rating region and category of service (COS) in order to make the appropriate adjustments to the base data for claims incurred but not paid.

Historical Program Changes

In order to structure the historical claims data base appropriately, Mercer reviewed prior rate setting documentation and other materials from the State to identify program changes that were implemented during the base data period. No mid-year adjustments were made in CY 2012 that materially impacted the ABD <21. Therefore, no historical program changes were made.

ENCLOSURE 3

Projected Cost Development

The adjusted base data (described in Enclosure 2) was brought forward to the contract period. The adjustments used to produce the projected costs are described within this section and listed below:

- Impact of Medicaid Expansion/Those Eligible But Not Enrolled (EBNE).
- Prospective Program Changes.
- Trend.

Impact of Medicaid Expansion/Those EBNE

The State decided to implement an adult expansion that provides coverage for parents with incomes from 91% to 138% (includes the 5% income disregard) of the federal poverty level (FPL), childless adults with incomes from 0% to 138% of FPL, and to enroll this new population into managed care. Separate rates were established for the new adult expansion population, which is referred to as Extension. Details regarding the rate development for the Medicaid Extension members were provided in a separate document.

Mercer also evaluated the impact on the existing program of a potential influx of those EBNE in Medicaid (commonly referred to as the woodwork population). This potential influx has been assumed to be immaterial on the ABD <21 population and thus, no explicit adjustment was made.

Prospective Program Changes

ODM and Mercer reviewed the program changes that could have a material effect upon the cost, utilization, or demographic structure of the program prior to or during the contract period, whose effect was not included within the base data. Several changes were evaluated for their impact on the CY 2015 rates.

Diagnosis Related Group (DRG) Rebase

Effective July 1, 2013, the State implemented a new DRG schedule updating the core pieces that affect hospital payments. Goals of the State regarding this change included the following:

- Reduce the frequency of outlier payments to be consistent with the intent of prospective payment systems.
- More appropriately reimburse for the following types of services/facilities:
  - Rural Facilities.
  - Deliveries.
  - Psychiatric Care.
  - Care for Kids — Impacts Children's Hospitals.

In order to estimate the impact of this program change to the ABD <21 population, Mercer relied upon analysis by its subcontractor, Burns and Associates, for an estimate of the impact to the Inpatient COS by rating region.
When evaluating the impact of the DRG rebase, the above adjustment should be considered, along with the other inpatient-related prospective program changes described later in this section, and the MCP inpatient pricing targets described in Enclosure 4.

Outpatient Facility Reimbursement Updates

Prior to January 1, 2014, the State reimbursed hospitals for certain outpatient services at percentage of cost. Effective January 1, 2014, payments for these services are paid at a set fee schedule amount except for chemotherapy services that continue to be paid at a percentage of cost. Services affected include: lab services, unlisted surgeries, unlisted ancillary codes, Paragraph “L”, independently billed pharmacy and medical supplies, intravenous therapy, and unlisted radiology codes.

Addition of Respite Services Benefit

The State received 1915(b)3 waiver authority from CMS to offer a new respite benefit for supplemental security income children whom the State approves for this new service.

Inpatient Reimbursement Reductions

Effective January 1, 2014, the capital component of the inpatient payment methodology was rebased using the latest available Medicaid cost report data (as has been done annually for many years). As part of the annual capital component update, the State also reduced the total hospital-specific capital costs by 15% as a result of the State’s participation in Medicaid Extension. In addition to the capital component updates, the hospital-specific per case base and the medical education base rate components were reduced by 5%. Children’s hospitals were exempt from both the 15% capital and base rate reductions.

Metabolic Nutrition Coverage Clarification

A small number of managed care enrollees had been receiving metabolic nutrition services from the Ohio Department of Health (ODH). To be consistent with the provider agreement requirements, the State provided clarification to the MCPs regarding their responsibility to provide all medically necessary metabolic nutrition services for all members, even those previously receiving these services from ODH. Since the base data does not include this experience, a rating adjustment was made to include the cost of metabolic nutrition services for these transitioning members.

DRG Rebase Refinement

Through discussions with the Ohio Hospital Association, changes were further made to base rates for some urban hospitals by expanding the risk corridor when compared to the pre- all patient refined (APR)-DRG system — from gains/losses that were +/- 3% using the prior methodology to +/- 5% using the prior methodology. This change was effective July 1, 2014, with a slight modification for some urban hospitals that was effective October 1, 2014, based on consultation with the Ohio Hospital Association.

After the application of the +/-5% stop loss/stop gain update, the inpatient unit cost represents the projected cost per admit for the midpoint of CY 2014 (July 2014). The trend adjustment, described later in this section, will trend the data forward from the midpoint of the base data (July 2012) to the midpoint of the contract period (July 2015). To ensure the final inpatient unit cost is appropriately trended to the midpoint of the CY 2015 contract period, the post DRG, rebase refinement inpatient unit cost was adjusted to change it from a CY 2014 basis, to CY 2012. This adjustment helps to ensure the final, trended inpatient unit cost is reflective of the expected unit cost during the contract year.

Professional Reimbursement Refinement

To be consistent with Medicare policies and procedures, the State has reduced payment for situations when multiple services are provided on the same day. Below is a summary of the updated reimbursement policies:

- Laboratory and radiology services:
  - Primary procedure is paid at 100% of the Medicaid fee schedule allowed amount.
  - Each additional global or technical component is reduced to 50% of the Medicaid fee schedule allowed amount.
  - Each additional professional component will be reduced to 75% of the Medicaid fee schedule allowed amount.
- Skilled therapies in the same discipline (for example, physical therapy):
  - Primary unit is paid at 100% of the Medicaid fee schedule allowed amount.
  - Subsequent units are paid at 80% of the Medicaid fee schedule allowed amount.

The above policy changes apply to services provided by non-institutional providers.

Non-DRG Hospital Reduction

Effective October 1, 2014, the State reimburses DRG-exempt facilities at 90% of cost and effective January 1, 2015, the James Cancer Center will be reimbursed at 94.7% of cost. This change applies to both inpatient and outpatient services.

Nurse and Aide Rate Update

The reimbursement for nurse and aide rates will be updated further on April 1, 2015, and a series of other changes will impact the current nurse and aide rate structure. This restructuring is intended to increase the quality of these services and ensure appropriate oversight of the provision of services. The changes include:

- Restructuring of home care attendant and nurse rates for Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) to ensure the appropriate staff are providing services and that reimbursement rates reflect the difference in staff credentials and requirements.
- Creation of rates for assessment and consultation by an RN when an LPN is providing services, ensuring appropriate oversight by RNs.
- Policy changes related to billing guidance for base rates.
- Rebalancing of base rates and 15-minute rates.

Trend

Trend is an estimate of the change in the cost of providing a specific set of benefits over time, resulting from both unit cost (price and service mix) and utilization changes. Trend factors are used to estimate the cost of providing services in some future year (contract year) based on the cost incurred in a prior period (base period).

Mercer considered several information sources to develop the appropriate trend factors to use in the State's rates. Several years of ABD <21 data by COS and the resulting trends were analyzed. This FFS data was a primary trend source. ABD <21 state fiscal year 2014 managed care data and six-month trends were also reviewed. Other sources, such as regional and national economic indicators and indices, provide broad perspectives of industry trends in the United States, the Midwest region, and the State. Examples of specific resources reviewed include the Department of Labor Consumer Price Index (local, regional, and national) data, federal reports and projections (for example, National Health Expenditures), and other health care industry reports (for example, Health Care Cost Institute). Mercer's proprietary information about other state Medicaid programs provides additional information about Medicaid patterns of care and how they affect trends. As part of the above, information regarding drugs that are moving off patent and those being introduced to the market is also used to inform the pharmacy trends.

ENCLOSURE 4

Adjustments to Reflect an Efficient Managed Care Environment

In addition to projecting the data forward (described in Enclosure 3), adjustments were made to reflect an efficient managed care environment. These adjustments are described within this section and are summarized below:

- Managed Care Adjustments.
- Provider Pricing Targets.
- Care Coordination Expenses and Non-Claim Expense Load.
- MCP/Hospital Incentive.
- Applicable Taxes.
- Affordable Care Act (ACA) Section 9010.
- Pay for Performance.

Managed Care Adjustments

In alignment with ODM's objective of purchasing more effective, efficient, and innovative health care, as well as actuarial rate setting assumptions moving from Medicaid FFS to managed care, Mercer applied utilization and unit cost adjustments by COS. For unit cost adjustments, information from MCP surveys was also considered (see the Provider Pricing Targets section).

Provider Pricing Targets

MCPs must develop the necessary networks to serve the projected ABD <21 population under managed care; Mercer has included a provision for a payment allowance above Medicaid FFS. The impact of contractor efficiency levels on the existing managed care programs and information in the MCP surveys was used to inform these targets. The ABD <21 pricing targets used in CY 2014 were retained for CY 2015. In addition, a new pricing target service grouping for Rad/Lab/Path services was added. To account for the facility and professional component of the Rad/Lab/Path consolidated COS, these targets utilized a combination of the Outpatient and Professional targets. The blend was developed based on the mix of facility and professional Rad/Lab/Path dollars by rating region.

Care Coordination Expenses and Non-Claim Expense Load

The actuarially sound capitation rates that were developed include provisions for MCP administration and underwriting gain, and risk and contingency, collectively referred to as the "non-claim expense load." Medicaid managed care administrative costs are higher than State costs to administer a FFS or primary care case management-style program, as a result of activities that MCPs undertake to manage care. For instance, Medicaid MCPs incur expenses related to provider contracting and credentialing, developing and implementing medical management protocols, and sponsoring disease management programs. These expenses are included in managed care capitation rates with the expectation that they produce more cost-effective patterns of care that result in improved health outcomes for Medicaid recipients.

To develop an appropriate value for the non-claim expense capitation component, Mercer reviewed CY 2013 and later the State's MCP covered families and children (CFC), ABD Adults (ABD 21+), and ABD <21 cost reports to identify recent and historical program administrative expenses. Mercer reviewed the total administrative services across the historical MCPs to determine the appropriate amount of administrative load to be added for, and allocated to

ABD <21. Administration costs were examined under the context of appropriateness for each respective managed care population (ABD 21+, CFC Non-Delivery, CFC Delivery, and ABD <21), separately and across the entire, projected managed care program in total. The primary data sources of this analysis included 2013 and the first half of 2014 MCP cost reports, and the most recent National Association of Insurance Commissioner's financial statements. Mercer compared trended administrative expenses to other industry benchmarks for reasonableness. Projected administrative expenses were converted to a percentage of the capitation rate and underwriting gain, and risk and contingency loads were added to produce the values shown in the table below. These values are expressed as a percentage of capitation excluding taxes, MCP/hospital incentives, or pay for performance bonuses.

MCP/Hospital Incentive

Effective July 1, 2011, the State implemented a MCP/Hospital Incentive program under which the MCPs are expected to increase payment levels to hospitals providing services to MCP enrollees. The aggregate $162 million that the MCPs are obligated to pay during the CY 2015 rate period will be distributed to the hospitals at the MCPs' discretion. The cost attributed to this change will be allocated across the various rate group/rating region combinations, based on the non-NF, inpatient per member per month costs attributable to each rate group. This allocation will be applied to CFC Non-Delivery, ABD 21+, and ABD <21 rate groups.

The funding for the MCP/Hospital Incentive has not been authorized by the legislature for the next biennium that starts on July 1, 2015. In the event that the funding for this initiative is repealed, the rates will need to be adjusted.

Applicable Taxes

MCPs are required to remit Sales and Use taxes, as well as a Health Insuring Corporation (HIC) tax on the revenue they receive. The HIC tax is 1% of revenue, and the Sales and Use tax varies by county. To determine appropriate regional Sales and Use tax rates for capitation purposes, Mercer evaluated county-level enrollment for each rating region and composited the county-level tax rates to a regional total.

ACA Section 9010

One of the components of the ACA is the requirement that health insurers pay a Health Insurance Providers Fee starting in CY 2014. Not-for-profit insurers with more than 80% of their premium from Medicaid, Medicare, and Children's Health Insurance Program risk contracts are exempt. ODM intends to handle any amounts due to the MCPs resulting from the costs associated with the Health Insurance Providers Fee as a separate capitation.

Pay for Performance

Effective January 1, 2015, 1.50% of total premium will be placed in the managed care program's performance payment fund and is available to the contracted MCPs as a bonus payment, above and beyond the contracted, actuarially sound capitation rates. The disposition of any bonus amount will be in accordance with Appendix O of the Provider Agreement.

ENCLOSURE 5

Risk-Adjustment Applications

To address concerns from the plans and additional stakeholders that variations in health risk may occur among the plans, the State has decided to implement the following techniques that will ultimately vary the payments made to the plans:

- Risk Adjust the ABD Capitation Rates.
- Hepatitis C Drug Risk Pool.

Risk Adjust the ABD Capitation Rates

ODM will use the combined the Chronic Illness & Disability Payment System and Medicaid Rx (CDPS+Rx) model to further adjust the ABD capitation payments. The CDPS+Rx model uses both diagnosis data on facility and professional records, in addition to pharmacy data, to classify individuals into disease conditions, along with member demographics (age and sex categories) to measure each MCP's anticipated health risk.

This risk-adjustment process uses historical FFS reimbursed claims and encounter data that were incurred over a 12-month period to classify recipients into CDPS+Rx disease conditions. This information is then combined with the anticipated cost associated with each of these CDPS+Rx model categories. The anticipated costs, referred to as cost weights, were developed specifically for a supplemental security income population by the CDPS+Rx model developers (the University of California, San Diego) based on a comprehensive benefit package that includes pharmacy. The combination of the CDPS+Rx categories and the appropriate cost weights produces a risk score for each recipient, referred to as an acuity factor. Acuity factors are only developed for recipients with at least six months of Medicaid eligibility within the 12-month study period. Recipients and their acuity factors are assigned to the MCPs and the average risk score, referred to as a case mix, for each MCP and rating region combination is calculated. To ensure that the risk-adjustment process does not increase or decrease the total capitation payments, the case mixes are adjusted for budget neutrality. The intent of this adjustment is to recalibrate the MCP risk scores to yield a population average of 1.000.

The State will separately risk adjust the ABD 21+ and ABD <21 rate groups for each rating region. The State intends to update the risk scores and the resulting risk-adjusted rates on a semi-annual basis, with the updates scheduled to occur in January and July of each year.

Hepatitis C Risk Pool Arrangement

With the advent of new Hepatitis C treatments, the State and the plans are concerned about the possibility that one or more plans could experience adverse selection among the Hepatitis C population using the new/high-cost drug treatments. To address this concern, the State has decided to implement a Hepatitis C risk pool, where the amount of the pool is determined by the projected Hepatitis C costs incorporated into the CY 2015 rates, and the funds will be redistributed among the plans based on relative actual Hepatitis C costs. This risk pool will be used to account for any plan(s) getting a disproportionate share of members using Hepatitis C drugs, by giving plans that experience adverse selection or relatively adverse claims experience a greater proportion of the risk pool funds. The risk pool is budget-neutral to the State.

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ENCLOSURE 1

MCP Rate Structure

The State and Mercer considered the potential risk variation of various subpopulations, along with the ease of operationalization, when determining the MCP rate structure. This section describes the rate group structure for the MCP programs.

Regions

For CY 2015, the MCP programs will operate in seven rating regions outlined below:

Table 1.1 — Rating Regions

Region	Rating Region
West	A1 — North Central
	A2 — Northwest
	A3 — Southwest
Central/Southeast	B1 — South Central
	B2 — Southeast
Northeast	C1 — Northeast
	C2 — Northeast Central

Rate Groups

For CY 2015, the capitation rates will be developed separately for each rating region and for the following 11 rate groups for the CFC and ABD 21+ populations.

Table 1.2 — Rate Groups (Program — Age — Gender)

Healthy Families (HF)/Healthy Start (HST) — <1 Male and Female (M+F)
HF/HST — 1 M+F
HF/HST — 2–13 M+F
HF/HST — 14–18 M
HF/HST — 14–18 F
HF — 19–44 M
HF — 19–44 F
HF — 45+ M+F
HST — 19–64 F
CFC Delivery
ABD 21+

The above rate structure includes a supplemental rate that will be paid upon evidence of a delivery event that meets the State's requirements for payment. This delivery payment is only applicable to delivery events for CFC members (and Medicaid Extension individuals, see separate certification) and covers the projected cost of the delivery event, along with some postpartum care. The costs associated with all other maternity expenses (prenatal and the postpartum care not included in the delivery payment) are included in the monthly capitation rates for each CFC rate cell. All maternity costs (prenatal, delivery, and postpartum) for the ABD 21+ population are included in the monthly capitation rates since this population is not eligible for the supplemental delivery payment.

The ABD 21+ rates will be risk adjusted to account for variations in health risk among the managed care plans. This process is described in greater detail in Enclosure 5.

ENCLOSURE 2

Historical (Base) Data Development

This section of the narrative describes the formation of the base data used to produce the databook and the following adjustments that were applied to produce the base data for rate development, which were applied after the release of the databook:

- Removal of Non-State Plan Services; Copayment Adjustments.
- Adjustment for Third Party Liability (TPL) and Fraud and Abuse (FA).
- Disproportionate Share Hospital (DSH) Payments.
- Graduate Medical Education (GME) Payments.
- Addition for Certain Expenditures Not Included in the Encounter Data.
- Completion for Additional Claims Run Out.
- Application of Historical Program Changes.

Base Data Construction/Databook Preparation

Mercer summarized the MCP cost report data for the time period of January 1, 2013 through December 31, 2013 to serve as the base data as reported in the databook. The net value of reinsurance (reinsurance expenses — reinsurance recoveries) was added to the cost report base and the costs associated with the Affordable Care Act's (ACA's) Section 1202 physician payments were removed. The data was examined for potential outliers or reporting issues at the program, MCP, rating region, rate group, and category of service (COS) level; no adjustments were deemed necessary. Adjustments were made to reflect the new rating regions effective July 2013 with the new provider agreement.

To support member-level adjustments and the rate groups, rating regions, and service mix, CY 2013 encounter data was used.

Removal of Non-State Plan Services; Copayment Adjustments

The base data was adjusted to remove the cost and utilization corresponding to Non-State Plan Services (NSPS), such as supplementary vision benefits. In addition, because some MCPs have waived recipient copays for some services, Mercer adjusted the base data unit cost to reflect the level of copay application used in the State's fee-for-service (FFS) environment. These adjustments were based on plan-reported NSPS and the value of copay waivers.

Adjustment for TPL and FA

To the extent that the data is not already net of recoveries from third party payers and FA recoveries, adjustment is appropriate. Mercer reviewed plan-reported information about these recoveries and how they are reflected in the base data.

DSH Payments

The inpatient and outpatient payments made by the MCPs exclude DSH payments. As a result, the rates are net of these payments and no adjustment was necessary to ensure that the rates are exclusive of DSH payments the hospital will receive outside of the capitation rates.

GME Payments

The inpatient payments made by the MCPs account for GME payments that are made to select hospitals. As a result, the rates include these payments within inpatient services.

Addition for Certain Expenditures Not Included in the Encounter Data

Non-emergent transportation, dental, and nursing facility (NF) (ABD 21+) services were underreported in the encounter data. Recognizing this, the expenditures for these services were taken directly from the cost reports, but adjusted to reflect the new rating regions.

Completion for Additional Claims Run Out

The base data includes plan-reported claims, including incurred but not paid (IBNP) estimates as reported in the CY 2013 cost reports. The plan-reported total incurred claims were adjusted based on supplemental IBNP information from the second quarter CY 2014 National Association of Insurance Commissioners (NAIC) financial statements.

Application of Historical Program Changes

In order to structure the historical base data appropriately, Mercer reviewed prior rate setting documentation and other materials from the State to identify program changes that were implemented during the base data period. To place the entire base period on a consistent basis, adjustments were made to the portion of the base data prior to the implementation of the program change.

Diagnosis Related Group (DRG) Rebase

Effective July 1, 2013, the State implemented a new DRG schedule updating the core pieces that affect hospital payments. Goals of the State regarding this change included the following:

- Reduce the frequency of outlier payments to be consistent with the intent of prospective payment systems.
- More appropriately reimburse for the following types of services/facilities:
  - Rural Facilities.
  - Deliveries.
  - Psychiatric Care.
  - Care for Kids — Impacts Children's Hospitals.

In order to estimate the impact of this program change to the CFC and ABD 21+ populations, Mercer relied upon analysis by its subcontractor, Burns and Associates, for an estimate of the impact by region. The CFC impact was applied on a rating region and rate group basis to the Inpatient COS.
This change was measured by comparing the plan-reported costs per admit in CY 2013 to the expected costs per admit using the All Patient Refined (APR)-DRG fee schedule in effect on July 1, 2013.

When evaluating the impact of the DRG rebase, the above adjustment should be considered, along with the inpatient-related prospective program changes in Enclosure 3 and the MCP inpatient pricing targets described in Enclosure 4.

ENCLOSURE 3

Projected Cost Development

The adjusted base data (described in Enclosure 2) was brought forward to the contract period. The adjustments used to produce the projected costs are described within this section and listed below:

- Impact of Medicaid Expansion/Those Eligible But Not Enrolled (EBNE).
- Prospective Program Changes.
- Trend.

Impact of Medicaid Expansion/Those EBNE

The State decided to implement an adult expansion that provides coverage for parents with incomes from 91% to 138% (includes the 5% income disregard) of the federal poverty level (FPL), childless adults with incomes from 0% to 138% of FPL, and to enroll this adult expansion population, which is referred to as Extension. Separate rates were established for the new Extension population. Details regarding the rate development for the Extension members are provided in a separate document.

Mercer also evaluated the impact on the existing managed care program of a potential influx into CFC of those currently EBNE in Medicaid (commonly referred to as the woodwork population) due to ACA health care reform efforts.

Prospective Program Changes

The State and Mercer reviewed the program changes that could have a material effect upon the cost, utilization, or demographic structure of the program prior to or during the contract period, whose effect was not included within the base data. Several changes were evaluated for their impact on the CY 2015 rates.

Outpatient Facility Reimbursement Updates

Prior to January 1, 2014, the State reimbursed hospitals for certain outpatient services at percentage of cost. Effective January 1, 2014, payments for these services are paid at a set fee schedule amount, except for chemotherapy services that continue to be paid at a percentage of cost. Services affected include: lab services, unlisted surgeries, unlisted ancillary codes, Paragraph “L”, independently billed pharmacy and medical supplies, intravenous therapy, and unlisted radiology codes.

Addition of Respite Services Benefit

The State received 1915(b)3 waiver authority from CMS to offer a new respite benefit for supplemental security income (SSI) children whom the State approves for this new service.

Inpatient Reimbursement Reductions

Effective January 1, 2014, the capital component of the inpatient payment methodology was rebased using the latest available Medicaid cost report data (as has been done annually for many years). As part of the annual capital component update, the State also reduced the total hospital-specific capital costs by 15% as a result of the State’s participation in Medicaid Extension. In addition to the capital component updates, the hospital-specific per case base and

the medical education base rate components were reduced by 5%. Children's hospitals were exempt from both the 15% capital and base rate reductions.

Metabolic Nutrition Coverage Clarification

A small number of managed care enrollees had been receiving metabolic nutrition services from the Ohio Department of Health (ODH). To be consistent with the provider agreement requirements, the State provided clarification to the MCPs regarding their responsibility to provide all medically necessary metabolic nutrition services for all members, even those previously receiving these services from ODH. Since the base data does not include this experience, a rating adjustment was made to include the cost of metabolic nutrition services for these transitioning members.

DRG Rebase Refinement

Through discussions with the Ohio Hospital Association, changes were further made to base rates for some urban hospitals by expanding the risk corridor when compared to the pre-APR-DRG system — from gains/losses that were +/- 3% using the prior methodology to +/- 5% using the prior methodology. This change was effective July 1, 2014, with a slight modification for some urban hospitals that was effective October 1, 2014, based on consultation with the Ohio Hospital Association

After the application of the +/-5% stop loss/stop gain update, the inpatient unit cost represents the projected cost per admit for the midpoint of CY 2014 (July 2014). The trend adjustment, described later in this section, will trend the data forward from the midpoint of the base data (July 2013) to the midpoint of the contract period (July 2015). To ensure the final inpatient unit cost is appropriately trended to the midpoint of the CY 2015 contract period, the post DRG, rebase refinement inpatient unit cost was adjusted to change it from a CY 2014 basis, to CY 2013. This adjustment helps to ensure the final, trended inpatient unit cost is reflective of the expected unit cost during the contract year.

Professional Reimbursement Refinement

To be consistent with Medicare policies and procedures, the State has reduced payment for situations when multiple services are provided on the same day. Below is a summary of the updated reimbursement policies:

- Laboratory and radiology services:
  - Primary procedure is still paid at 100% of the Medicaid fee schedule allowed amount.
  - Each additional global or technical component is reduced to 50% of the Medicaid fee schedule allowed amount.
  - Each additional professional component will be reduced to 75% of the Medicaid fee schedule allowed amount.
- Skilled therapies in the same discipline (for example, physical therapy):
  - Primary unit is still paid at 100% of the Medicaid fee schedule allowed amount.
  - Subsequent units are paid at 80% of the Medicaid fee schedule allowed amount.

The above policy changes apply to services provided by non-institutional providers.

Non-DRG Hospital Reduction

Effective October 1, 2014, the State reimburses DRG-exempt facilities at 90% of cost and effective January 1, 2015, the James Cancer Center will be reimbursed at 94.7% of cost. This change applies to both inpatient and outpatient services.

Former Inmate Outreach Program

As inmates in correctional facilities prepare to be discharged and returned to the community, the State will be contacting the soon-to-be released inmates to determine Medicaid eligibility and have those who are Medicaid eligible prepare to enroll into one of the participating MCPs. The former inmate would then be immediately enrolled into their selected MCP upon release from the facility, which could be any time during the month. As a result of this policy, it is expected that the former inmates will be enrolling into the Medicaid/MCP program much earlier than has occurred historically. Recognizing that inmate populations typically have higher acuity (for example, greater incidence of substance abuse, psychiatric conditions, or infectious diseases) than other populations typically enrolled in managed care, an upward rate adjustment was applied to the adult rate cells expected to enroll former inmates. This adjustment was developed from the implementation schedule and summarized inmate reports supplied by the State that contained information regarding health status and demographic profiles of inmates.

The rating adjustment made for the former inmate program assumed a half month of service for the month of discharge because members could be enrolling throughout the month. However, due to system constraints the State cannot prorate capitation payments. To account for this, a full member month was included for each month the former inmate will be enrolled in an MCP.

Addition of Periodontal Scaling and Root Planing Services

The State is updating the dental benefit to include the addition of scaling and root planing services starting in the first quarter of 2015.

Nurse and Aide Rate Update

The reimbursement for nurse and aide rates will be updated further on April 1, 2015, and a series of other changes will impact the current nurse and aide rate structure. This restructuring is intended to increase the quality of these services and ensure appropriate oversight of the provision of services. The changes include:

- Restructuring of home care attendant and nurse rates for Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) to ensure the appropriate staff are providing services and that reimbursement rates reflect the difference in staff credentials and requirements.
- Creation of rates for assessment and consultation by an RN when an LPN is providing services, ensuring appropriate oversight by RNs.
- Policy changes related to billing guidance for base rates.
- Rebalancing of base rates and 15-minute rates.

Trend

Trend is an estimate of the change in the cost of providing a specific set of benefits over time, resulting from both unit cost (price and service mix) and utilization changes. Trend factors are used to estimate the cost of providing services in some future year (contract year) based on the cost incurred in a prior period (base period).

Mercer considered several information sources to develop appropriate trend factors to use in the State's rates. Analysis of MCP encounter and financial data (including the CY 2013 cost reports, first half CY 2014 cost reports, and the first half 2014 Ohio Department of Insurance NAIC financial statements) were primary sources of information that provided insight into particular trend patterns within the ODM environment. MCP encounter and financial experience trends reflect a variety of influences, including potential changes in medical management practices, network construction, and population risk. Some of these influences may be accounted for in other aspects of rate setting, such as program changes, managed care assumptions, or demographic mix, and as such, MCP experience trends must be considered within the broader set of information about underlying trend. Other sources, such as regional and national economic indicators and indices, provide broad perspectives of industry trends in the United States, the Midwest region, and the State. Examples of specific resources reviewed include the Department of Labor Consumer Price Index data (local, regional, and national), federal reports and projections (for example, National Health Expenditures), and other health care industry reports (for example, Health Care Cost Institute). Mercer's proprietary information about other state Medicaid programs provides additional information about Medicaid patterns of care and how they affect trends. As part of the above, information regarding drugs that are moving off patent and those being introduced to the market is also used to inform the pharmacy trends.

ENCLOSURE 4

Adjustments to Reflect an Efficient Managed Care Environment

In addition to trending the data forward (described in Enclosure 3), adjustments were made to reflect an efficient managed care environment. These adjustments are described within this section and are summarized below:

- Managed Care Efficiency Adjustments.
- Provider Pricing Targets.
- Care Coordination Expenses and Non-Claim Expense Load.
- MCP/Hospital Incentive.
- Applicable Taxes.
- ACA Section 9010.
- Pay for Performance.

Managed Care Efficiency Adjustments

In alignment with the State's objective of purchasing more effective, efficient, and innovative managed care, Mercer implemented provider unit cost pricing targets and efficiency adjustments, the latter focusing on non-emergent ED use, potentially preventable inpatient admissions, and increasing pharmacy utilization management and pricing efficiency effectiveness.

Provider Pricing Targets

To ensure that unit cost levels in the MCP experience are appropriate to use as a baseline for the program contract period, the State collects information about MCP provider payment levels. After reviewing the collected information and discussion with the State, the pricing targets used in prior years were retained for CY 2015, except for inpatient services, which were returned to their targeted levels prior to the DRG rebase. In addition, a new pricing target service grouping for Rad/Lab/Path services was added. Since Rad/Lab/Path has a facility and a professional component, this adjustment utilized a combination of the Outpatient and Professional targets. The blend was developed based on the mix of facility and professional Rad/Lab/Path dollars by region and population.

ED Efficiency Adjustment

Mercer performed a retrospective analysis of the MCPs' CY 2013 Emergency Room (ER) encounter data to identify ED visits (excludes urgent care visits) that were considered avoidable due to the low-acuity nature of the visit. This analysis is not intended to imply that beneficiaries should be denied access to EDs, nor that the MCPs should deny payment for the ED visits. Instead, the analysis was designed to reflect the State's objective that more effective, efficient, and innovative managed care could have prevented or preempted the need for some beneficiaries to seek care in the ED.

Using Mercer-identified, low-acuity non-emergent (LANE) diagnosis and procedure codes compiled through clinical literature review, Mercer scanned the CY 2013 Ohio Medicaid encounter data for ED visits where LANE diagnoses appeared as the primary diagnosis on both the facility claim and any associated physician claim.

While the relevant literature typically considers all such ED visits as non-emergent and/or emergent but primary care treatable or potentially preventable, Mercer applied additional filters on the data to inform an appropriate rate adjustment. The Mercer clinical team, working with a Mercer subcontracted, practicing ED physician, developed for each diagnosis a target percentage of visits to be considered for adjustment. This target varies by diagnosis, taking into consideration the circumstances under which Medicaid populations present at the ED and ultimately have the LANE diagnosis assigned as their final (primary) diagnosis. Mercer then calculated a “LANE dollars to remove” value by identifying ED visits for removal up to the target percentage, pulling them hierarchically from visits with procedure codes 99281, 99282, 99283, and “unclassified,” until the target percentage of visits was removed. No visits with a 99284 or 99285 procedure code were removed, even if that meant the target visit removal could not be achieved.

Only a portion of the LANE adjustment was applied to the laboratory/radiology component of the ER visit, as some of these services would have been appropriate services had they been performed as part of or resulting from a physician office visit.

Finally, to produce final rate adjustments for LANE, Mercer offset the “LANE dollars to remove” amount with the value of an average physician office visit for approximately 95% of the visits removed. This replacement cost was determined by adding service units to the Office Visits/Consults COS in direct proportion with those removed from the ER Professional COS. This adjustment was applied at the region and rate cell level.
Note: Even though the costs associated with urgent care facilities are included in the ER COS, the services performed in an urgent care facility are excluded from the LANE adjustment.

Inpatient Hospital Efficiency Adjustment

Since hospital expenses represent a significant portion of all health care medical expenditures, Mercer performed a retrospective data analysis of the MCP CY 2013 encounter data using condition indicators developed by the Agency for Healthcare Research and Quality (AHRQ). These conditions are collectively referred to as prevention quality indicators (PQI) and pediatric quality indicators (PDI), respectively. Mercer utilized 13 adult PQIs and five pediatric PDIs as part of the analysis. Evidence suggests that hospital admissions for these conditions could have been avoided through high-quality outpatient care and/or the conditions could have been less severe if treated early and appropriately. AHRQ’s technical specifications provide specific criteria that define each PQI and PDI that Mercer utilized in the analysis of the MCP inpatient hospital encounter data. Although AHRQ acknowledges that there are factors outside of the direct control of the health care system that can result in a hospitalization (for example, environmental and patient compliance), AHRQ does recognize that these types of PDI/PQI analyses can be utilized to benchmark health care system efficiency between facilities and across geographies.

In the process of evaluating whether an adjustment was appropriate, Mercer considered the following factors: member health risk and member enrollment duration with a particular MCP.

Although the AHRQ technical specifications do not account for enrollment duration, Mercer considered enrollment duration as one of the contributing factors that would be associated with the applicability of a PQI/PDI-based adjustment. Enrollment duration was used as a proxy for

issues such as patient compliance, MCP outreach and education, time to intervene, and other related concepts. Mercer clinical and actuarial staff determined that a variable-month enrollment duration ranging from two to 12 months, depending on PQI or PDI condition, would be appropriate for the CY 2015 rates. This assumption meant that an individual had to be enrolled with the same MCP for a minimum amount of consecutive months prior to that individual's PQI or PDI hospital admission to be considered subject to the adjustment. Only the dollars associated with the PQI and PDI hospital admissions that met this enrollment duration criteria were included in the base data adjustment. Recipient eligibility data supplied by the State was used to determine member duration.

While AHRQ technical specifications include exclusionary criteria specific to each PQI and PDI, Mercer additionally considered clinically-based global exclusion criteria that removed a member's inpatient admission claims from the analysis. The global exclusion criteria developed by the Mercer clinical team was utilized to identify certain conditions and situations (for example, indications of trauma, burns, HIV/AIDS) that may require more complex treatment for members. Based on a review of the CY 2013 inpatient encounter data, any member identified as having indications of any of the qualifying conditions resulted in all of that member's admissions being removed from the analysis.

Only the dollars associated with the PQI or PDI hospital admissions that remain after the application of the duration and clinical exclusions were used to form the potentially preventable admissions (PPA) base data adjustment. The value of the PPA adjustment includes only the facility component of the service. The professional component associated with the PPA remains with the base data because it is expected that in an efficient managed care environment, professional services would need to be provided in order to successfully avoid the PPA.

Maximum Allowable Cost Pharmacy Pricing

Mercer performed a retrospective data analysis of the MCP pharmacy encounter data to determine if the generic pricing methods used by the MCPs and their pharmacy benefit managers were reasonable and appropriate, given the pricing that has been achieved by other nearby Medicaid programs and by each MCP in the State. Each generic drug claim was re-priced using an industry benchmark Medicaid Administrative Claiming (MAC) list for the same date of service. For each pharmacy claim for which there was a benchmark MAC unit price in place on the claim's date of service, the claim paid amount was compared to the derived paid amount using the MAC unit price benchmark. Each claim was re-priced regardless of whether the benchmark price was higher or lower than the original amount on the claim line.

Outpatient Pharmacy Utilization Retrospective Analysis

Mercer performed a retrospective analysis of the MCP pharmacy encounter data to identify inappropriate prescribing and/or dispensing patterns using a customized series of clinical rules-based, pharmacy utilization management edits. These edits were developed by Mercer's Managed Pharmacy Practice based on published literature, industry standard practices, clinical appropriateness review, professional expertise, and information gathered during the review of several Medicaid managed care pharmacy programs across the country.

The customized edits reviewed individual pharmacy claims to identify issues related to inappropriate dosage limits and quantity limits, therapeutic duplication issues, excessive opiate

use based on morphine equivalent doses per day thresholds, excessive use of acetaminophen, and age, gender, and pregnancy-related issues.

A relatively small percentage of the MCPs' total pharmacy claim volume met the customized edit criteria for inappropriate prescribing and/or dispensing. To accommodate for pharmacy claims that had received clinical prior authorization review by the MCP, Mercer utilized information contained in the prior authorization data field on each pharmacy claim to determine if the claim had an administrative prior authorization value (for example, refilling too soon) or contained a value consistent with a clinical prior authorization (for example, repeating sequence of number per individual recipient or indication of prior authorization in the data request). Based on this determination, Mercer removed from the analysis any pharmacy claim that appeared to have undergone prior authorization review for clinical appropriateness, as well as any claim where the MCP would not have had the opportunity to impose any clinical rules (for example, emergency fill). To ensure that a prescription was only counted once in the analysis, a priority ranking was assigned to each edit. For example, if a pharmacy claim met the criteria for a quantity limit edit, as well as narcotic overutilization edit, the claim and the associated dollars were only counted once for purposes of the rate adjustment. As a result, each customized pharmacy edit was assigned a total dollar figure reflecting the value of all unduplicated pharmacy claims that met the criteria associated with that edit.

Although the criteria associated with each edit is clinically sound, it is expected that situations exist in which clinical or operational rationale support the payment of a claim that did not meet the initial criteria, thus, resulting in an adjustment factor that varied by edit. Such rationale includes, but is not limited to, clinical practice guidelines, eligibility data issues, off-label prescribing practices, medication titration issues, individual patient response to therapy, and professional judgment.

Finally, the adjustment value for this analysis took into consideration the probability that a certain percentage of the pharmacy claims that met the edit criteria could have been modified and appropriately prescribed in another manner (for example, prescribed as a different medication or as a different dosage strength). Mercer considers these cost offsets, which were directly applied to decrease the final adjustment value.

Care Coordination Expenses and Non-Claim Expense Load

The actuarially sound capitation rates that were developed include provisions for MCP administration and underwriting gain, and risk and contingency, collectively referred to as the "non-claim expense load." Medicaid managed care administrative costs are higher than State costs to administer FFS or primary care case management-style program, as a result of activities that MCPs undertake to manage care. For instance, Medicaid MCPs incur expenses related to provider contracting and credentialing, developing and implementing medical management protocols, and sponsoring disease management programs. These expenses are included in managed care capitation rates with the expectation that they produce more cost-effective patterns of care that result in improved health outcomes for Medicaid recipients.

To develop an appropriate value for the non-claim expense capitation component, Mercer reviewed CY 2013 and later the State's MCP CFC and ABD 21+ cost reports to identify recent

and historical program administrative expenses. Mercer compared trended administrative expenses to other industry benchmarks for reasonableness.

MCP/Hospital Incentive

Effective July 1, 2011, the State implemented a MCP/Hospital Incentive program under which the MCPs are expected to increase payment levels to hospitals providing services to MCP enrollees. The aggregate $162 million that the MCPs are obligated to pay during the CY 2015 rate period will be distributed to the hospitals at the MCPs' discretion. The cost attributed to this change will be allocated across the various rate group/rating region combinations, based on non-NF inpatient per member per month costs attributable to each rate group. This allocation will be applied to CFC Non-Delivery, ABD 21+, and ABD <21 rate groups.

The funding for the MCP/Hospital Incentive has not been authorized by the legislature for the next biennium that starts on July 1, 2015. In the event that the funding for this initiative is repealed, the rates will need to be adjusted.

Applicable Taxes

MCPs are required to remit Sales and Use taxes, as well as a Health Insuring Corporation (HIC) tax on the revenue they receive. The HIC tax is 1% of revenue, and the Sales and Use tax varies by county. To determine appropriate regional Sales and Use tax rates for capitation purposes, Mercer evaluated county-level enrollment for each rating region and composited the county-level tax rates to a regional total.

ACA Section 9010

One of the components of the ACA is the requirement that health insurers pay a Health Insurance Providers Fee starting in CY 2014. Not-for-profit insurers with more than 80% of their premium from Medicaid, Medicare, and Children’s Health Insurance Program risk contracts are exempt. The State intends to handle any amounts due to the MCPs resulting from the costs associated with the Health Insurance Providers Fee as a separate capitation.

Pay for Performance

Effective January 1, 2015, 1.50% of total premium will be placed in the managed care program’s performance payment fund and is available to the contracted MCPs as a bonus payment, above and beyond the contracted, actuarially sound capitation rates. The disposition of any bonus amount will be in accordance with Appendix O of the Provider Agreement.

ENCLOSURE 5

Risk-Adjustment Applications

To address concerns from the plans and additional stakeholders that variations in health risk may occur among the plans, the State has decided to implement the following techniques that will ultimately vary the payments made to the plans:

- Risk Adjust the ABD Capitation Rates.
- Hepatitis C Drug Risk Pool.

Risk Adjust the ABD Capitation Rates

The State will use the combined Chronic Illness & Disability Payment System and Medicaid Rx (CDPS+Rx) model to further adjust the ABD capitation payments. The CDPS+Rx model uses both diagnosis data on facility and professional records, in addition to pharmacy data, to classify individuals into disease conditions, along with member demographics (age and sex categories) to measure each MCP's anticipated health risk.

This risk-adjustment process uses historical FFS reimbursed claims and encounter data that were incurred over a 12-month period to classify recipients into CDPS+Rx disease conditions. This information is then combined with the anticipated cost associated with each of these CDPS+Rx model categories. The anticipated costs, referred to as cost weights, were developed specifically for a SSI population by the CDPS+Rx model developers (the University of California, San Diego) based on a comprehensive benefit package that includes pharmacy. The combination of the CDPS+Rx categories and the appropriate cost weights produces a risk score for each recipient, referred to as an acuity factor. Acuity factors are only developed for recipients with at least six months of Medicaid eligibility within the 12-month study period. Recipients and their acuity factors are assigned to the MCPs and the average risk score, referred to as a case mix, for each MCP and rating region combination is calculated. To ensure that the risk-adjustment process does not increase or decrease the total capitation payments, the case mixes are adjusted for budget neutrality. The intent of this adjustment is to recalibrate the MCP risk scores to yield a population average of 1.000.

The State will separately risk adjust the ABD 21+ and ABD <21 rate groups for each rating region. The State intends to update the risk scores and the resulting risk-adjusted rates on a semi-annual basis, with the updates scheduled to occur in January and July of each year.

Hepatitis C Risk Pool Arrangement

With the advent of new Hepatitis C treatments, the State and the plans are concerned about the possibility that one or more plans could experience adverse selection among the Hepatitis C population using the new/high-cost drug treatments. To address this concern, the State has decided to implement a Hepatitis C risk pool, where the amount of the pool is determined by the projected Hepatitis C costs incorporated into the CY 2015 rates, and the funds will be redistributed among the plans based on relative actual Hepatitis C costs. This risk pool will be used to account for any plan(s) getting a disproportionate share of members using Hepatitis C drugs, by giving plans that experience adverse selection or relatively adverse claims experience a greater proportion of the risk pool funds. The risk pool is budget-neutral to the State.

ENCLOSURE 1

MCP Rate Structure

The State and Mercer considered the potential risk variation of various subpopulations along with the ease of operationalization when determining the Extension rate structure. This section describes the rate group structure for the Extension program.

Regions

For CY 2015, the MCP programs will be operated in the seven rating regions outlined below:

Table 1.1 — Rating Regions

Region	Rating Region
West	A1 — North Central
	A2 — Northwest
	A3 — Southwest
Central/Southeast	B1 — South Central
	B2 — Southeast
Northeast	C1 — Northeast
	C2 — Northeast Central

Rate Groups

For CY 2015, the capitation rates will be developed separately for each rating region and the following eight rate groups. Thus, there are 56 Non-Delivery distinct rate groups developed for the Extension population:

Table 1.2 — Rate Groups (Program — Age — Gender)

Extension — 19 to 34 M
Extension — 19 to 34 F
Extension — 35 to 44 M
Extension — 35 to 44 F
Extension — 45 to 54 M
Extension — 45 to 54 F
Extension — 55 to 64 M
Extension — 55 to 64 F

In addition to the above rate groups, MCPs will receive a delivery payment for each Extension member with a qualifying event. The same Delivery rate (given the similar risk) will be used for both Covered Families and Children (CFC) and Extension members. The development of this rate is described in the CFC and Aged, Blind, or Disabled Adults (ABD 21+) CY 2015 Capitation Rate Development Methodology letter.

Subpopulations for Rate Development Support

Each Extension rate group is comprised of the following four subgroups that are expected to have different underlying costs and influences on the Extension rates:

Table 1.3 — Extension Subpopulations

Parents (91% to 138% of the Federal Poverty Level [FPL]) Disabled-like
Parents (91% to 138% FPL) CFC-like
Childless Adults (0% to 138% FPL) Disabled-like
Childless Adults (0% to 138% FPL) CFC-like

ENCLOSURE 2

Projected Medical Cost (Base) Data Development

Since no historical experience exists for this new population, an alternative rate base was established using the projected claim costs for the CFC and ABD adult populations. The Extension population is assumed to be less healthy and thus more expensive than the CFC adult population. As a proxy for a portion of these higher-cost individuals, Mercer has utilized the ABD adult population, and refers to this higher cost subgroup as “Disabled-like.” This does not imply nearness to actual disability status, only significantly higher estimated cost. For the Disabled-like members, the ABD adult projected managed care experience was used. For the CFC-like members, the CFC adult projected managed care experience was used. This data was split into the Extension rate groups using the January through June 2012 encounter data that was used for rating region and rate group distribution for the CFC and ABD adult populations. Thus, age/gender relativities were unchanged. The following adjustments were already applied to the CY 2015 projected managed care experience:

- Removal of Non-State Plan Services; Copayment Adjustments.
- Adjustment for Third-Party Liability and Fraud and Abuse Recoveries.
- Addition for Certain Expenditures Not Included in the Encounter Data.
- Completion for Additional Claims Run Out.
- Application of Historical Program Changes (Including Eligible But Not Enrolled).
- Prospective Program Changes (except for the Former Inmate Outreach Program described in Enclosure 3).
- Trend.
- Managed Care Efficiency Adjustments.

Once the base claim costs were established for each rating region, rate group, and subpopulation, the claim costs of each subpopulation were blended together to produce the base experience for each Extension rating region and rate group combination.

Considerations for the mix of subpopulations include the first half of 2014-reported financial experience from the second quarter 2014 cost reports, and data regarding the Extension population that remained in fee-for-service (FFS) but are expected to enroll in MCPs in the second half of 2014.

Claim Cost Adjustments

In addition to the adjustments inherent in the base data described above, further specific adjustments were necessary to account for the unique circumstances attributable to the Extension population and to project program costs into CY 2015.

Maternity Non-Delivery Costs

The Extension population is expected to have proportionately fewer deliveries than the underlying CFC population. As a result, the maternity costs that are typically covered through the monthly capitation payments (which exclude the actual delivery costs), are expected to be lower.

ENCLOSURE 3

Adjustments to Reflect an Efficient Managed Care Environment

In addition to using the projected CFC and ABD adult medical costs that serve as the Extension rate base, adjustments were made to reflect an increasingly efficient managed care environment during the second year of the program, along with further adjustments that are specific to the Extension population. These adjustments are described within this section and are summarized below:

- Pent-Up Demand.
- Former Inmate Outreach Program.
- Managed Care Adjustments.
- Enrollment of Members in Nursing Facilities.
- Care Coordination Expenses and Non-Claim Expense Load.
- MCP/Hospital Incentive.
- Applicable Taxes.
- Affordable Care Act (ACA) Section 9010.
- Pay for Performance.

Pent-Up Demand

Since the Extension population presumably has had little to no access to health care recently, health care demand is assumed to be materially suppressed. It is expected that in the initial 12-months following the enrollment of an Extension member, services will be used at a higher pace than in the eventual steady-state.

Former Inmate Outreach Program

As inmates in correctional facilities prepare to be discharged and returned to the community, the State will be contacting the soon-to-be released inmates to determine Medicaid eligibility and have those who are Medicaid eligible prepare to enroll into one of the participating MCPs. The former inmate would then be immediately enrolled into their selected MCP upon release from the facility, which could be any time during the month. As a result of this policy, it is expected that the former inmates will be enrolling into the Medicaid/MCP program much earlier than has occurred historically. Recognizing that inmate populations typically have higher acuity (greater incidence of substance abuse, psychiatric conditions, or infectious diseases, for example) than other populations typically enrolled in managed care, an upward rate adjustment was applied to the adult rate cells expected to enroll former inmates. This adjustment was developed from the implementation schedule and summarized inmate reports supplied by the State that contained information regarding health status and demographic profiles of inmates.

The rating adjustment made for the former inmate program assumed a half month of service for the month of discharge because members could be enrolling throughout the month. However, due to system constraints the State cannot prorate capitation payments. To account for this, a full member month was included for each month the former inmate will be enrolled in an MCP.

Managed Care Adjustments

As the underlying claims costs for the Extension population are based on CFC and ABD adults, this experience reflects a very mature managed care environment. Recognizing that managed care techniques may take time to integrate and to achieve efficient and effective care delivery adjustments were made to reflect the likely reduced managed care abilities of the MCPs during the second year of the Extension population.

Enrollment of Members in Nursing Facilities (NFs)

In the underlying CFC and ABD adult populations, members are enrolled in the MCPs until the end of the second month of NF stay, at which time the member is dis-enrolled from the managed care program and retains FFS Medicaid eligibility. In the Extension population, members will remain in the managed care program throughout the duration of any NF stay. To account for this change in the underlying risk, non-dual FFS NF duration was examined to determine the average length of stay in a NF in FFS.

Care Coordination Expenses and Non-Claim Expense Load

In addition to the claim costs, component loads were incorporated into the Extension rates to account for administrative expense (fixed and variable), medical management/care coordination, risk/contingency, and applicable taxes. With the exception of risk/contingency, the same underlying approach outlined in the CFC and ABD 21+ rate development was applied to the Extension rates.

MCP/Hospital Incentive

The amount of the MCP/Hospital Incentive had already been fully allocated across the CFC, ABD 21+, and ABD <21 rates. Therefore, no adjustment was needed for the Extension rates.

Applicable Taxes

MCPs are required to remit Sales and Use taxes, as well as a Health Insuring Corporation (HIC) tax on the revenue they receive. The HIC tax is 1% of revenue, and the Sales and Use tax varies by county. To determine appropriate regional Sales and Use tax rates for capitation purposes, Mercer evaluated county-level enrollment for each rating region and composited the county-level tax rates to a regional total.

ACA Section 9010

One of the components of the ACA is the requirement that health insurers pay a Health Insurance Providers Fee starting in CY 2014. Not-for-profit insurers with more than 80% of their premium from Medicaid, Medicare, and Children's Health Insurance Program risk contracts are exempt. ODM intends to handle any amounts due to the MCPs resulting from the costs associated with the Health Insurance Providers Fee as a separate capitation.

Pay for Performance

Effective January 1, 2015, 1.50% of total premium will be placed in the managed care program's performance payment fund and will be available to the contracted MCPs as a bonus payment, above and beyond the contracted, actuarially sound capitation rates. The disposition of any bonus amount will be in accordance with Appendix O of the Provider Agreement.

ENCLOSURE 4

Risk-Adjustment Applications

To address concerns from the plans and additional stakeholders that variation in certain health risk may occur among the plans, the State has decided to implement the following techniques that will ultimately vary the payments made to the plans:

- Risk-Adjustment.
- Hepatitis C Drug Risk Pool.

Risk-Adjustment

The State intends to risk adjust the Extension rates starting sometime in CY 2015. The details regarding the risk-adjustment application are still being discussed and will be shared with the plans when finalized.

Hepatitis C Risk Pool Arrangement

With the advent of new Hepatitis C treatments, the State and the plans are concerned about the possibility that one or more plans could experience selection among the Hepatitis C population using the new/high-cost drug treatments. To address this concern, the State has decided to implement a Hepatitis C risk pool, where the amount of the pool is determined by the projected Hepatitis C costs incorporated into the CY 2015 rates, and the funds will be redistributed among the plans based on relative actual Hepatitis C costs. This risk pool will be used to account for any plan(s) getting a disproportionate share of members using Hepatitis C drugs, by giving plans that experience adverse selection or relatively adverse claims experience, a greater proportion of the risk pool funds. The risk pool is budget neutral to the State.

APPENDIX F

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APPENDIX G

COVERAGE AND SERVICES

1. Basic Benefit Package

Pursuant to OAC rule 5160-26-03(A), with limited exclusions, limitations and clarifications (see OAC rule 5160-26-03(H) and section G.2 of this appendix), MCPs must ensure that members have access to medically-necessary services covered by the Ohio Medicaid fee-for-service (FFS) program, and any additional services as specified in OAC rule 5160-26-03 and this Agreement. For information on Medicaid-covered services, MCPs must refer to the Ohio Department of Medicaid (ODM) website. MCP represents and warrants that services provided by the MCP to Extension Members comport with the Mental Health Parity and Addiction Equity Act (MHPAEA) and shall provide written evidence of such as requested by ODM. The following includes but is not limited to a general list of services covered through the MCP benefit package:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinics (RHCs) and federally qualified health centers (FQHCs)
- Physician services whether furnished in the physician's office, the covered person's home, a hospital, or elsewhere
- Laboratory and x-ray services
- Screening, diagnosis, and treatment services to children under the age of twenty-one (21) under the Healthchek, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program
- Family planning services and supplies
- Home health and private duty nursing services
- Podiatry
- Chiropractic services
- Physical therapy, occupational therapy, developmental therapy, and speech therapy
- Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services

- Free-standing birth center services in free-standing birth centers as defined in OAC 5160-18-01
- Prescription drugs
- Ambulance and ambulette services
- Dental services
- Durable medical equipment and medical supplies
- Vision care services, including eyeglasses
- Nursing facility stays as specified in OAC rule 5160-26-03 for ABD and CFC members. For Adult Extension members, nursing facility stays are covered as long as medically necessary.
- Hospice care
- Behavioral health services (see section G.2.b.iii of this appendix)
- Immunizations (*MCPs must follow the coverage requirements provided by ODM for any newly approved vaccine under the Vaccines for Children (VFC) program)
- Preventive services covered by Ohio Medicaid in accordance with Section 4106 of the Affordable Act and 42 CFR 440.130(c).
- All U.S. Preventive Services Task Force (USPSTF) grade A and grade B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration, without cost-sharing, as provided in section 4106 of the Affordable Care Act. Additionally, MCPs must cover without cost-sharing, services specified under Public Health Service Act section 2713 in alignment with the Alternative Benefit Plan.
- Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit, as described in OAC rule 5160-4-34
- Respite services for Supplemental Security Income (SSI) members under the age of 21, as approved by CMS within the applicable 1915(b) waiver and as described in OAC rule 5160-26-03.
- Telemedicine

2. <u>Exclusions, Limitations and Clarifications</u>

a. Exclusions

MCPs are not required to pay for FFS program non-covered services, except as specified in OAC rule 5160-26-03. For information regarding Medicaid non-covered services, MCPs must refer to the ODM website. The following includes but is not limited to a general list of the services not covered by the FFS program:

- Services or supplies that are not medically necessary
- Treatment of obesity unless medically necessary
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid, and not in accordance with customary standards of practice.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
- Infertility services for males or females
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
- Reversal of voluntary sterilization procedures
- Plastic or cosmetic surgery that is not medically necessary*
- Sexual or marriage counseling
- Acupuncture and biofeedback services
- Services to find cause of death (autopsy) or services related to forensic studies
- Paternity testing
- Services determined by another third-party payor as not medically necessary.
- Drugs not covered by the Ohio Medicaid pharmacy program as specified in OAC 5160-9-03, including drugs for the treatment of obesity.
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual. This does not pertain to withholding or withdrawing medical treatment, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death.

- Medical services if the service was caused by a provider-preventable condition as defined in 42 CFR 447.26. The prohibition on payment for provider-preventable conditions shall not result in a loss of access to care or services for Medicaid consumers.

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

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

b. Limitations & Clarifications

i. Member Cost-Sharing

As specified in OAC rules 5160-26-05(D) and 5160-26-12, MCPs are permitted to impose the applicable member co-payment amount(s) for dental services, vision services, non-emergency emergency department services, or prescription drugs, MCPs must notify ODM if they intend to impose a co-payment. ODM must approve the notice to be sent to the MCP's members and the timing of when the co-payments will begin to be imposed. If ODM determines that an MCP's decision to impose a particular co-payment on their members would constitute a significant change for those members, ODM may require the effective date of the co-payment to coincide with the "Open Enrollment" month.

Notwithstanding the preceding paragraph, MCPs must provide an ODM-approved notice to all their members 90 days in advance of the date that the MCP will impose the co-payment. With the exception of member co-payments the MCP has elected to implement in accordance with OAC rules 5160-26-05(D) and 5160-26-12, the MCP's payment constitutes payment in full for any covered services and their subcontractors must not charge members or ODM any additional co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise.

ii. Abortion and Sterilization

The use of federal funds to pay for abortion and sterilization services is prohibited unless the specific criteria found in federal law and OAC rules 5160-17-01 and 5160-21-02.2 are met. MCPs must verify that all of the information on the applicable required forms (ODM 03197, ODM 03199, HHS-687 and HHS-687-1 (SPANISH VERSION)) is provided and that the service meets the required criteria before any such claim is paid.

Additionally, payment must not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion or sterilization itself does not qualify for payment. MCPs are responsible for educating their providers on the

requirements; implementing internal procedures including systems edits to ensure that claims are only paid once the MCP has determined if the applicable forms are completed and the required criteria are met, as confirmed by the appropriate certification/consent forms; and for maintaining documentation to justify any such claim payments. If MCPs have made the determination that the requirements associated with an abortion, sterilization, or hysterectomy were sufficiently met by the facility/provider, then no additional information (i.e. operative notes, history and physical, ultrasound etc.) is required from ancillary providers.

iii. Behavioral Health Services

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

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

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

- Medicaid-covered prescription drugs when prescribed by an MHA-certified or MHA-certified provider and obtained through an MCP's panel pharmacy.

- Medicaid-covered, provider-administered medications including:

    1. Injectable long-acting 2nd generation antipsychotic drugs, haloperidol, haloperidol decanoate, lorazepam, fluphenazine decanoate, and valium when administered by an ODMH-certified provider.
    2. Generic buprenorphone for induction and/or titration and vivitrol (injectable naltrexone) when administered by MHA-certified provider.

    When administered as a medical benefit, MCPs shall reimburse MHA-certified or MHA-certified providers for Medicaid-covered, provider-administered medications listed above at the lesser of 100% of the

provider's cost or 100% of the Ohio Medicaid program fee-for-service reimbursement rate.

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

- Physician services in an Institution for Mental Disease (IMD), as defined in Section 1905(i) of the Social Security Act, as long as the member is 21 years of age and under, or 65 years of age and older.

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

  Mental Health: MCPs are responsible for ensuring access to counseling and psychotherapy, physician/psychologist/psychiatrist services, outpatient clinic services, general hospital outpatient psychiatric services, pre-hospitalization screening, diagnostic assessment (clinical evaluation), crisis intervention, psychiatric hospitalization in general hospitals (for all ages) and laboratory services. For Adult Extension members, MCPs are responsible for providing medically necessary psychological services as described in Ohio's CMS-approved Alternative Benefit Package.

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

v. <u>Limitations:</u>

- MCPs <u>are not</u> responsible for paying for behavioral health services provided through MHA-certified CMHCs and MHA-certified Medicaid providers;

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

- MCPs are not responsible for providing mental health services to persons between 22 and 64 years of age while residing in an institution for mental disease (IMD) as defined in Section 1905(i) of the Social Security Act. MCPs are not prohibited from contracting with an IMD to provide mental health services to persons between 22 and 64 years of age, but the MCP will not be compensated by Medicaid for the provision of such services (i.e. either through

direct payment or considering any associated costs in the Medicaid rate setting process).

vi. Pharmacy Benefit:

a. In providing the Medicaid pharmacy benefit to their members, MCPs must cover the same drugs covered by the FFS program, in accordance with OAC rule 5160-26-03(A) and (B). However, pursuant to ORC Section 5167.12, MCPs may, subject to ODM approval, implement strategies for the management of drug utilization. (See appendix K.2.f.i).

b. MCPs must participate in quarterly meetings to obtain prior ODM approval of changes to the MCP list of drugs requiring prior authorization. Unless otherwise authorized by ODM, the quarterly meeting process will ensure that the combined list of drugs requiring prior authorization for each MCP results in a combined percentage agreement that is no less than seventy percent. MCPs must publish a thirty (30) days advance notice of changes to the MCP list of drugs requiring prior authorization, via their website, on both the provider and member web pages.

c. MCPs are not permitted to require prior authorization (PA) in the case of a drug to which all of the following apply:

(i) The drug is an antidepressant or antipsychotic.
(ii) The drug is administered or dispensed in a standard tablet or capsule form, except that in the case of an antipsychotic, the drug also may be administered or dispensed in a long-acting injectable form.
(iii) The drug is prescribed by either of the following:
(a) An MCP panel provider psychiatrist;
(b) A psychiatrist practicing at a CMHC;
(iv) The drug is prescribed for a use that is indicated on the drug's labeling, as approved by the federal food and drug administration.

d. Notwithstanding paragraph 31.g of Appendix C, MCPs may require PA for antidepressant or antipsychotic drugs that do not meet the criteria outlined in paragraph b, above. MCPs must consider the prescribing provider's verification that the member is stable on the specific medication when making the PA decision.

vii. Organ Transplants: MCPs must ensure coverage for organ transplants and related services in accordance with OAC 5160-2-07.1 (B)(4) & (5). Coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium" based on criteria established by Ohio organ transplant surgeons and authorization from the

ODM prior authorization unit. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC 3701:84-01, is contingent upon review and recommendation by the "Ohio Hematopoietic Stem Cell Transplant Consortium" again based on criteria established by Ohio experts in the field of bone marrow transplant. While MCPs may require prior authorization for these transplant services, the approval criteria would be limited to confirming the consumer is being considered and/or has been recommended for a transplant by either consortium. Additionally, in accordance with OAC 5160-2-03 (A)(4) all services related to organ donations are covered for the donor recipient when the consumer is Medicaid eligible.

3. Information Sharing with Non-Panel Providers

To assist members in accessing medically-necessary Medicaid covered services, MCPs are required to share specific information with certain non-panel providers. The information is to assist non-panel providers to recognize MCP membership, access information needed to provide services and if applicable successfully submit claims to the MCP.

a. ODM-Designated Providers

Per OAC rule 5160-26-03.1(A)(4), MCPs must share specific information with MHA-certified CMHCs, MHA-certified Medicaid providers, FQHCs/RHCs, qualified family planning providers [QFPPs], hospitals and if applicable, certified nurse midwives [CNMs], certified nurse practitioners [CNPs], and free-standing birth centers (FBCs) as defined in OAC 5160-18-01 within the MCP's service area and in bordering regions if appropriate based on member utilization information. The information must be shared within the first month after the MCP has been awarded a Medicaid provider agreement for a specific region and annually thereafter. At a minimum, the information must include the following:

- the information's purpose;
- claims submission information including the MCP's Medicaid provider number for each region (this information is only required to be provided to non-panel FQHCs/RHCs, QFPPs, CNMs, CNPs and hospitals);
- the MCP's prior authorization and referral procedures;
- a picture of the MCP's member ID card (front and back);
- contact numbers for obtaining information for eligibility verification, claims processing, referrals/prior authorization, post-stabilization care services and if applicable information regarding the MCP's behavioral health administrator;
- a listing of the MCP's laboratories and radiology providers; and
- a listing of the MCP's contracting behavioral health providers and how to access services through them (this information is

only required to be provided to non-panel MHA-certified CMHCs and MHA-certified Medicaid providers).

b. MCP-authorized Providers

Per OAC rule 5160-26-05(A)(6), MCPs authorizing the delivery of services from a non-panel provider must ensure that they have a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph D of OAC rule 5160-26-05. This notice is provided when an MCP authorizes a non-panel provider to furnish services on a one-time or infrequent basis to an MCP member and must include required ODM-model language and information. This notice must also be included with the transition of services form sent to providers as outlined in Section 31. of Appendix C.

APPENDIX H

PROVIDER PANEL SPECIFICATIONS

1. FEDERAL ACCESS STANDARDS

MCPs must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as assure that they are in compliance with the following federally defined provider panel access standards as required by 42 CFR 438.206:

In establishing and maintaining their provider panel, MCPs must consider the following:

- The anticipated Medicaid membership.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the MCP.
- The number and types (in terms of training, experience, and specialization) of panel providers required to deliver the contracted Medicaid services.
- The geographic location of panel providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.
- MCPs must adequately and timely cover services provided by an out-of-network provider if the MCP's contracted provider panel is unable to provide the services covered under the MCP's provider agreement. The MCP must cover the out-of-network services for as long as the MCP network is unable to provide the services. MCPs must coordinate with the out-of-network provider with respect to payment and ensure that the provider agrees with the applicable requirements.

Contracting providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. MCPs must ensure that services are available 24 hours a day, 7 days a week, when medically necessary. MCPs must establish mechanisms to ensure that panel providers comply with timely access requirements, and must take corrective action if there is failure to comply.

In order to demonstrate adequate provider panel capacity and services, 42 CFR 438.206 and 438.207 stipulates that the MCP must submit documentation to the Ohio Department of Medicaid (ODM), in a format specified by ODM, that demonstrates it offers an appropriate range of preventive, primary care and specialty services adequate for the anticipated number of members in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area.

This documentation of assurance of adequate capacity and services must be submitted to ODM no less frequently than at the time the MCP enters into a contract with ODM; at any time there is a significant change (as defined by ODM) in the MCP's operations that would affect adequate

capacity and services (including changes in services, benefits, geographic service or payments); and at any time there is enrollment of a new population in the MCP.

2. GENERAL PROVISIONS

The ODM provider panel requirements are specified in the charts included with this appendix and must be met prior to the MCP receiving a provider agreement with ODM. The MCP must remain in compliance with these requirements for the duration of the provider agreement.

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

If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may **not** be counted toward this trip limit (as specified in Appendix C).

In developing the provider panel requirements, ODM considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD and CFC consumers, as well as the potential availability of the designated provider types. ODM has integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODM requires providers to be located anywhere in the region.

ODM will recalculate the minimum provider panel specifications if ODM determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population. The Managed Care Provider Network (MCPN) is the tool that will be used for ODM to determine if the MCPs meet all the panel requirements that are identified within Appendix H; therefore, the plans must enter all network providers as specified within the file specs.

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

3. PROVIDER SUBCONTRACTING

Unless otherwise specified in this appendix or OAC rule 5160-26-05, all MCPs are required to enter into fully-executed subcontracts with their providers. These subcontracts must include a baseline contractual agreement, as well as the appropriate ODM-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable OAC rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCP's name.

MCPs may not employ or contract with providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act. Only those providers who meet the applicable criteria specified in this document, and as determined by ODM, will be counted toward meeting minimum panel requirements. MCPs must credential/re-credential providers in accordance with OAC rule 5160-26-05. The MCP must ensure that the provider has met all applicable credentialing criteria before the provider can, be listed as a panel provider. At the direction of ODM, the MCPs must submit documentation verifying that all necessary contract documents have been appropriately completed.

The MCPN is a centralized database system that maintains information on the status of all MCP-submitted providers. MCPs must notify ODM of the addition and deletion of their contracting providers as specified in OAC rule 5160-26-05, and must notify ODM within one working day, in instances where the MCP has identified that they are not in compliance with the provider panel requirements specified in this appendix. For provider deletions, MCPs must complete and submit an electronic record terminating the provider from the MCPN or other designated system.

4. PROVIDER PANEL REQUIREMENTS

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

a. Primary Care Providers (PCPs)

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

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

The PCP capacity for a county is the total amount of members that all of the PCPs in an MCP agree to serve in that county. ODM will determine the PCP capacity based on information submitted by the MCP through the MCPN. The PCP capacity must exceed by at least 5% the total number of members enrolled in the MCP during the preceding month in the same county. ODM will determine an MCP's compliance with this PCP capacity requirement each quarter using the ODM enrollment report for the previous month. For example, in March, ODM will review an MCP's countable PCP capacity using one of the March MCPN reports. The countable capacity will be compared to the finalized enrollment report for February.

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

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

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

b. Non-PCP Provider Network

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

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

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

All Medicaid-contracting MCPs must provide all medically-necessary Medicaid-covered services to their members and therefore their complete provider network will include many other additional specialists and provider types. MCPs must ensure that all non-PCP network providers follow community standards in the scheduling of routine appointments (i.e., the amount of time members must wait from the time of their request to the first available time when the visit can occur).

Hospitals - MCPs must contract with the number and type of hospitals specified by ODM for each county/region. In developing these hospital requirements, ODM considered, on a county-by-county basis, the population size and utilization patterns of the Ohio Medicaid ABD and CFC consumers and integrated the existing utilization patterns into the hospital network requirements to avoid disruption of care. For this reason, ODM may require that MCPs contract with out-of-state hospitals (i.e. Kentucky, West Virginia, etc.).For each Ohio hospital, ODM utilizes the hospital's most current Annual Hospital Registration and Planning Report, as filed with the Ohio Department of Health (ODH), in verifying types of services that hospital provides. Although ODM has the authority, under certain situations, to obligate a non-contracting hospital to provide non-emergency hospital services to an MCP's members, MCPs must still contract with the specified number and type of hospitals unless ODM approves a provider panel exception (see Section 5 of this appendix, *Provider Panel Exceptions*).
If an MCP-contracted hospital elects not to provide specific Medicaid-covered hospital services because of an objection on moral or religious grounds, the MCP must ensure that these hospital services are available to its members through another MCP-contracted hospital in the specified county/region.

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

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

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

Vision Care Providers - MCPs must contract with at least the minimum number of ophthalmologists/ optometrists for each specified county/region, all of whom must maintain a full-

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

Dental Care Providers - MCPs must contract with at least the minimum number of dentists.

FQHCs/RHCs - MCPs are required to ensure member access to any FQHCs/RHCs, regardless of contracting status. Contracting FQHC/RHC providers must be submitted for ODM review via the MCPN process, or other designated process. Even if no FQHC/RHC is available within the region, MCPs must have mechanisms in place to ensure coverage for FQHC/RHC services in the event that a member accesses these services outside of the region.

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

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

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

Additionally, MCPs must:

- Provide FQHCs/RHCs the MCP's Medicaid provider number(s) for each region to enable FQHC/RHC providers to bill for the ODM wraparound payment.

- Educate their staff and providers on the need to assure member access to FQHC/RHC services.

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

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

Behavioral Health Providers – MCPs must assure member access to all Medicaid-covered behavioral health services for members as specified in Appendix G.2. b.iii. herein. Although ODM is aware that certain outpatient substance abuse services may only be available through Medicaid providers certified by the Ohio Department of Mental Health and Addiction Services (MHA) in some areas, MCPs must maintain an adequate number of contracted mental health providers in the region to assure access for members who are unable to timely access services or unwilling to access services through community mental health centers. MCPs may contract with ODMH community mental health centers and/or MHA alcohol and other drug treatment providers for medical services based on MCP business or operational needs intended to enhance patient-centered medical home and care coordination. These contracts must expressly prohibit payment for services for which the non-federal share of the cost is provided by a board of alcohol, drug addiction and mental health services or a state agency other than ODM.

Pharmacies – Each MCP must provide or arrange for the delivery of all medically necessary Medicaid-covered pharmacy services. When medically necessary, compounding service and same-day home delivery must also be provided or arranged.

Each MCP's pharmacy network must include at least one retail pharmacy provider per county unless any of the following apply:

(1) no retail pharmacies are located in the county;
(2) the MCP has offered the retail pharmacies in the county the opportunity to contract with the MCP at similar rates offered by the Medicaid fee-for-service program so it is anticipated that aggregate payment for dispensed drugs will not be less than the aggregate amount reimbursed by the Medicaid fee-for-service program; or
(3) available retail pharmacies in a county fail to meet the MCP's quality or program integrity standards.

Irrespective of the requirement and exceptions above, the MCP must contract with at least one retail pharmacy in one of the adjoining counties.

Effective July 1, 2015:

- MCP must update maximum allowable cost (MAC) and other pricing benchmarks on a schedule at least as consistent as is required by CMS for Medicare Part D plans found at 42 CFR 423.505(b)(21); and
- MCP must work cooperatively with ODM and its designees, providing ODM with sufficient data and information to enable ODM to secure federal drug rebates for drugs administered to members at pharmacies as well as at physician offices, clinics, and other non-institutional settings. Each MCP must also assist ODM and its designees with the

resolution of drug manufacturer disputes regarding claims for federal drug rebates for drugs dispensed or administered to an MCP's member.

- MCP must establish Medicaid-specific BIN and PCN numbers for point-of-sale pharmacy claims processing, to ensure that MCP's BIN and PCN numbers for Medicaid claims are not the same as for the MCP's commercial or Medicare part D business lines.

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

5. PROVIDER PANEL EXCEPTIONS

Failure to contract with, and properly report to the MCPN, the minimum necessary panel will result in sanctions as outlined in Appendix N. ODM will grant an exception to the issuance of a sanction only when an action taken by ODM has adversely impacted a plan's ability to meet the provider panel network standards.

6. PROVIDER DIRECTORIES

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

MCP provider directories must utilize a format specified by ODM. Directories may be region-specific or include multiple regions, however, the providers within the directory must be divided by region, county, and provider type, in that order.

The directory must also specify:

- provider address(es) and phone number(s);
- an explanation of how to access providers (e.g., referral required vs. self-referral);
- an indication of which providers are available to members on a self-referral basis;
- foreign-language speaking PCPs and specialists and the specific foreign language(s) spoken;
- how members may obtain directory information in alternate formats that takes into

consideration the special needs of eligible individuals including but not limited to, visually-limited, LEP, and LRP eligible individuals,
- any PCP or specialist practice limitations; and
- An indication of whether the provider is accepting new members.

Printed Provider Directory

Prior to executing a provider agreement with ODM, all MCPs must develop a printed provider directory that shall be prior-approved by ODM. Once approved, this directory may be regularly updated with provider additions or deletions by the MCP without ODM prior-approval, however, a copy of the revised directory (or inserts) must be submitted to ODM prior to distribution to members.

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

Internet Provider Directory

MCPs are required to have an internet-based provider directory available in a format prior approved by ODM. This internet directory must allow members to electronically search for MCP panel providers based on name, provider type, and geographic proximity. If an MCP has one internet-based directory for multiple populations, each provider must include a description of which population they serve.

The internet directory may be updated at any time to include providers who are **not** one of the ODM-required provider types listed on the charts included with this appendix. ODM-required providers **must** be added to the internet directory within one week of submitting the provider to the MCPN. Providers being deleted from the MCP's panel must be deleted from the internet directory within one week of notification from the provider to the MCP. Providers being deleted from the MCP's panel must be posted to the internet directory within one week of notification from the provider to the MCP of the deletion. These deleted providers must be included in the inserts to the MCP's printed provider directory referenced above.

7. MANAGED CARE PROVIDER NETWORK PERFORMANCE MEASURES

ODM contracts with an External Quality Review Organization (EQRO), to conduct telephone surveys of providers' offices to validate information submitted in the MCPN files. These results will be used to evaluate MCP performance on a SFY basis. Sanctions for these measures are included in Appendix N of this agreement.

The following elements are included in the development of the composite performance measure:

- Rate of primary care provider (PCP) locations that were able to be reached
- Participating PCP locations still contracted with the MCP
- PCP locations accepting new members

In each quarterly telephone audit, these elements are defined by the following measures: Measure 1 (M1) identifies the proportion of the PCP locations not reached during a quarterly audit. The PCP was considered "not reached" after meeting one of the following three conditions: (1) the provider is no longer practicing at the sampled location, (2) the provider did not return phone calls after the EQRO made two contact attempts at different times during the survey, or (3) the provider declined to participate in the survey when contacted. The measure is an inverse measure such that the higher the percentage of PCP locations not reached, the lower the level of performance.

$$\text{(M1) Percent of PCP Locations Not Reached} = \frac{\text{Number of PCP Locations Not Reached}}{\text{Total Number of PCP Locations}}$$

The second measure (M2) reports the proportion of the PCP locations no longer contracted with the identified MCP at the time of the audit. This measure is also inverted such that a higher rate indicates lower performance.

$$\text{(M2)Percent of PCP Locations Not Contracted with MCP} = \frac{\text{Number of PCP Locations Not With MCP}}{\text{Number of PCP Locations Reached}}$$

Measure 3 (M3) examines the percentage of PCP locations whose response to the telephone survey question regarding the acceptance of new patients matched the data contained in the MCPN file.

$$\text{(M3) Accepting New Patient Field Accuracy Rate} = \frac{\text{Number of PCP Locations with Accepting New Patients Response Matched with Those in MCPN File}}{\text{Number of Reached PCP Locations Still Contracted With MCP}}$$

During the first two years of implementing new performance measures the performance standards will be established from the baseline results. This method ensures that the initial standards are clearly defined in relation to current MCP performance. In the third year, following implementation of these measures, the standards would begin to incorporate performance levels supported by the historical analysis.

Measure 1: PCP Locations Not Reached

For measure 1, the standards during the first two years following implementation of the measure will be based on the distribution of MCPs' scores during the baseline period. The standard for Year 3 takes into account the historical statewide average over the first two years.

Table 1—Performance Standards for Measure 1: *PCP Location Not Reached*		
Year	**Proposed Standard**	**Methodology**
Year 1[1]	TBD	Upper 95% confidence limit from the statewide average during the baseline period
Year 2	TBD	Statewide average from the baseline period
Year 3	TBD	Five percentage points below the Year 2 standard

[1]Year 1 is considered the first year performance benchmarks are implemented.

Measure 2: PCP Locations Not Contracted With MCP

For Measure 2, the proposed standards are based on the distribution of MCPs' scores during the baseline period for the first two years following implementation of the measure. The standard for Year 3 takes into account the historical statewide average over the first two years.

Table 2—Performance/Compliance Standards for Measure 2: *PCP Location Not Contracted with MCP*		
Year	**Proposed Standard**	**Methodology**
Year 1[1]	TBD	Upper 95% confidence limit from the statewide average during the baseline period
Year 2	TBD	Statewide average from the baseline period
Year 3	TBD	Two standard deviations above the historical statewide average

[1]Year 1 is considered the first year performance standards are implemented.

Measure 3: Accepting New Patient Field Accuracy Rate

For Measure 3, the proposed standards for the first two years are based on baseline estimates. The standard for Year 3 takes into account the anticipated improvement in performance made by the MCPs over the first two years.

Table 3— Performance/Compliance Standards for Measure 3: *Accepting New Patient Field Accuracy Rate*		
Year	**Proposed Benchmark**	**Methodology**
Year 1[1]	TBD	Upper 95% confidence limit from baseline estimate for overall MCP
Year 2	TBD	Statewide average from baseline estimate for overall MCP
Year 3	TBD	Seven percentage points above Year 2

[1]Year 1 is considered the first year performance standards are implemented.

West Region

	Adams	Allen	Auglaize	Brown	Butler	Champaign	Clark	Clermont	Clinton	Darke	Defiance	Fulton	Greene	Hamilton	Hancock	Hardin	Henry	Highland	Lucas
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county																		
Minimum Contracted PCPs	5.0	9.0	3.0	5.0	27.0	3.0	16.0	13.0	4.0	3.0	3.0	3.0	9.0	66.0	5.0	2.0	2.0	5.0	55.0

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

Hospitals																			
General Hospital		1					1		1	1	1	1	1	1	1			1	
Hospital System														2					1

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

Practitioners																			
Allergists		1												4					1
Cardiovascular														1					1
Dentists	1	5	1	1	13	1	6	5	1	1		2	3	34	2	1	1	3	26
Gastroenterology																			1
General Surgeons		1			3		3	2	2				3	10				2	2
Nephrology																			
Neurology																			1
OB/GYNs		3		2	3		3	1	1				2	13	1				7
Oncology																			
Orthopedists		3			3								2	7	2				3
Otolaryngologist		1			1		1							4					3
Pediatricians		4			7		2	2	1		1		3	39	1				23
Physical Med Rehab																			1
Podiatry					1									2					2
Psychiatry		1											1	3					3
Urology																			1
Vision		3	1		4		3	1	2	1	2		3	14	1			2	9

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

West Region

	Mercer	Miami	Montgomery	Ottawa	Paulding	Preble	Putnam	Sandusky	Seneca	Shelby	Van Wert	Warren	Williams	Wood	Wyandot	Additional Required: In-Region	Total
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county																
Minimum Contracted PCPs	2.0	6.0	51.0	3.0	2.0	3.0	2.0	5.0	5.0	3.0	2.0	6.0	4.0	5.0	2.0	36.0	375.0

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

Hospitals																	
General Hospital	1	1	1					1		1	1		1		1	4	22
Hospital System			1														4

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

Practitioners																	
Allergists			2													10	18
Cardiovascular			1									1				6	10
Dentists	1	3	23	1			1	3	2	1	1	3	1	2	1	11	161
Gastroenterology																4	5
General Surgeons		1	4									1		1		6	41
Nephrology																3	3
Neurology																5	6
OB/GYNs	1	1	9					2	2	1		2		2		4	60
Oncology																3	3
Orthopedists		3	3					1		1				1		7	36
Otolaryngologist			4									1				10	25
Pediatricians		1	22					1						2		31	140
Physical Med Rehab																5	6
Podiatry			2											1		5	13
Psychiatry			2													7	17
Urology																6	7
Vision	2	2	13					2		1	1	2	1	2		9	81

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

Northeast Region

	Ashland	Ashtabula	Carroll	Columbiana	Cuyahoga	Erie	Geauga	Holmes	Huron	Lake	Lorain
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county										
Minimum Contracted PCPs	4.0	12.0	3.0	12.0	148.0	6.0	2.0	2.0	6.0	11.0	25.0

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

Hospitals											
General Hospital	1	1		1	1	1	1	1	1	1	1
Hospital System					1						

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

Practitioners											
Allergists					2						1
Cardiovascular					3						1
Dentists	3	3		3	85	2	1		2	6	11
Gastroenterology					2						
General Surgeons				2	18	2			2	2	3
Nephrology					1						
Neurology					2						
OB/GYNs		1		2	24	2			1	1	3
Oncology											
Orthopedists					12	1				1	3
Otolaryngologist					3						2
Pediatricians	1	1		2	66	2				3	8
Physical Med Rehab					2						
Podiatry					4						2
Psychiatry					5						3
Urology					2						
Vision		3			32	2	1		2	6	11

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

Northeast Region

	Mahoning	Medina	Portage	Richland	Stark	Summit	Trumbull	Tuscarawas	Wayne	Additional Required: In-Region	Total Required
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county										
Minimum Contracted PCPs	27.0	7.0	9.0	12.0	31.0	45.0	20.0	8.0	7.0	10.0	407.0
*Any additional required capacity must be located within the region.											
Hospitals											
General Hospital	1	1	1	1	1	1	1	1	1	2	21
Hospital System						1				1	3
* General hospitals must provide obstetrical services if such a hospital is available in the county/region.											
Practitioners											
Allergists					1	1				4	9
Cardiovascular	1				1	1				4	11
Dentists	14	4	3	7	17	23	11	4	3	3	205
Gastroenterology										4	6
General Surgeons	4	2	1	3	4	6	2	1	2	5	59
Nephrology										3	4
Neurology										4	6
OB/GYNs	4	1		1	7	12	3		1	7	70
Oncology										3	3
Orthopedists	3	1		1	2	3	1		1	11	40
Otolaryngologist	2				3	3				7	20
Pediatricians	10	3	2	3	14	20	6	2	2	17	162
Physical Med Rehab										4	6
Podiatry					1	2				4	13
Psychiatry	3				2	3	2			5	23
Urology										5	7
Vision	5	4		2	7	13	4			8	100
*All required providers and additional required providers must be located within the region.											

Central/Southeast Region

	Athens	Belmont	Coshocton	Crawford	Delaware	Fairfield	Fayette	Franklin	Gallia	Guernsey	Harrison	Hocking	Jackson	Jefferson	Knox	Lawrence	Licking	Logan
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county																	
Minimum Contracted PCPs	6.0	7.0	4.0	4.0	5.0	10.0	3.0	120.0	5.0	6.0	2.0	4.0	5.0	8.0	5.0	10.0	13.0	4.0

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

Hospitals																		
General Hospital	1	1	1	1		1	1	1	1	1				1	1		1	1
Hospital System								2										

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

Practitioners																		
Allergists								2										
Cardiovascular								2	1									
Dentists	3	4	1	1	3	4	1	60	1	3		1	1	3	3	3	4	1
Gastroenterology								1										
General Surgeons		2		1	2	3		20	2	2				2	1		1	1
Nephrology								1										
Neurology								1										
OB/GYNs	2				3	3		18		2				2	1		1	
Oncology																		
Orthopedists						2		10	2								2	
Otolaryngologist					2			14	2						1		1	1
Pediatricians	1	1			4	3		55	2	1				1	1		2	1
Physical Med Rehab								1										
Podiatry		1			1			3										
Psychiatry		1				1		5										
Urology																		
Vision	3	4	1	2	3	3		20	2	2			2	3	2	3	2	2

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

Central/Southeast Region

	Madison	Marion	Meigs	Monroe	Morgan	Morrow	Muskingum	Noble	Perry	Pickaway	Pike	Ross	Scioto	Union	Vinton	Washington	Additional Required: In-Region	Total Required
Total PCP Member Capacity	At least 5% more than previous month's member enrollment for each county																	
Minimum Contracted PCPs	3.0	7.0	4.0	1.0	2.0	3.0	12.0	2.0	5.0	5.0	5.0	10.0	13.0	3.0	1.0	6.0	14.0	317.0
*Any additional required capacity must be located within the region.																		
Hospitals																		
General Hospital	1	1					1			1		1	1	1		1	6	27
Hospital System																		2
General hospitals must provide obstetrical services if such a hospital is available in the county/region																		
Practitioners																		
Allergists																	3	5
Cardiovascular																	4	7
Dentists	1	3				1	4		1	1	1	4	2	1		3	16	135
Gastroenterology																	4	5
General Surgeons		1					2			1		2	2	1		1	6	53
Nephrology																	2	3
Neurology																	2	3
OB/GYNs		1					2					1	1			2	10	49
Oncology																	2	2
Orthopedists		2										2					9	29
Otolaryngologist		1					2					1	1	1			3	30
Pediatricians	1	2					2			1		2	2	1		1	33	117
Physical Med Rehab																	4	5
Podiatry							1										5	11
Psychiatry							1										6	14
Urology																	6	6
Vision		2					4			1		2	2	1		2	11	79
*All required providers and additional required providers must be located within the region.																		

Nursing Facility Provider Panel

Region	County	# NF
Central/SE	Delaware	3
Central/SE	Franklin	16
Central/SE	Madison	1
Central/SE	Pickaway	2
Central/SE	Union	1
Northeast	Portage	2
Northeast	Stark	11
Northeast	Summit	14
Northeast	Wayne	5
Northeast	Cuyahoga	31
Northeast	Geauga	2
Northeast	Lake	4
Northeast	Lorain	4
Northeast	Medina	4
Northeast	Columbiana	5
Northeast	Mahoning	7
Northeast	Trumbull	7
West	Fulton	2
West	Lucas	12
West	Ottawa	2
West	Wood	4
West	Butler	7
West	Clermont	4
West	Clinton	1
West	Hamilton	23
West	Warren	6
West	Clark	4
West	Greene	3
West	Montgomery	12

APPENDIX I

PROGRAM INTEGRITY

MCPs must comply with all applicable state and federal program integrity requirements, including, but not limited to, those specified in 42 CFR 455 and 42 CFR 438 Subpart H.

1. Fraud and Abuse Program:
In addition to the specific requirements of OAC rule 5160-26-06, MCPs must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan to guard against fraud and abuse. The MCP's compliance plan must designate staff responsibility for administering the plan and include clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and explain how the MCP will determine the compliance plan's effectiveness.

In addition to the requirements in OAC rule 5160-26-06, the MCP's compliance program which safeguards against fraud and abuse must, at a minimum, specifically address the following:

a. Employee education about false claims recovery: In order to comply with Section 6032 of the Deficit Reduction Act of 2005 MCPs must, as a condition of receiving Medicaid payment, do the following:

i. Establish and make readily available to all employees, including the MCP's management, the following written policies regarding false claims recovery:

a. Detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil or criminal penalties;

b. The MCP's policies and procedures for detecting and preventing fraud, waste, and abuse; and

c. The laws governing the rights of employees to be protected as whistleblowers.

ii. Include in any employee handbook the required written policies regarding false claims recovery;

iii. Establish written policies for any MCP contractors and agents that provide detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil or criminal penalties; the laws governing the rights of employees to be protected

as whistleblowers; and the MCP's policies and procedures for detecting and preventing fraud, waste, and abuse. MCPs must make such information readily available to their subcontractors; and

iv. Disseminate the required written policies to all contractors and agents, who must abide by those written policies.

b. Monitoring for fraud and abuse: The MCP's program which safeguards against fraud and abuse must specifically address the MCP's prevention, detection, investigation, and reporting strategies in at least the following areas:

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

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

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

iii. Claims submission and billing – On an ongoing basis, MCPs must identify and correct claims submission and billing activities which are potentially fraudulent including, at a minimum, double-billing and improper coding, such as upcoding and bundling, to the satisfaction of the Ohio Department of Medicaid (ODM).

c. Reporting MCP fraud and abuse activities: Pursuant to OAC rule 5160-26-06, MCPs are required to submit annually to ODM a report which summarizes the MCP's fraud and abuse activities for the previous year in each of the areas specified above. The MCP's report must also identify any proposed changes to the MCP's compliance plan for the coming year.

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

e. Reporting fraud and abuse: MCPs are required to promptly report all instances of suspected provider fraud and abuse to ODM and member fraud to the CDJFS. The MCP,

at a minimum, must report the following information on cases where the MCP's investigation has revealed that an incident of fraud and/or abuse has occurred:

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

ii. Source of complaint and date reported to or discovered by the MCP;

iii. Type of provider;

iv. Nature of complaint, including:
   a. Category of Service
   b. Factual explanation of the allegation
   c. Specific Medicaid statutes, rules, regulations, and/or policies violated
   d. Date(s) of conduct;

v. Approximate range of dollars involved, if applicable;

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

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

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

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

g. The MCP must disclose any change in ownership and control information and this information must be furnished to ODM within 35 days in accordance with 42 CFR 455.104 and 5160-1-17.3.

h. In accordance with 42 CFR 455.105, the MCP must submit within 35 days of the date requested by ODM or HHS full and complete information about:
   i. the ownership of any subcontractor with whom the MCP has had business transactions totaling more than $25, 000 during the 12-month period ending on the date of the request.
   ii. any significant business transactions between the MCP and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

i. The MCP must disclose the following information on persons convicted of crimes in accordance with 42 CFR 455.106 who:
   i. has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
   ii. has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

   This information must also be disclosed at any time upon written request by the Medicaid agency. The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure referenced in this section.

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

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

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

a. MCP Submissions: MCPs must submit the appropriate ODM-developed certification concurrently with the submission of the following data or documents:

   i. Encounter Data [as specified in the Data Quality Appendix (Appendix L)]

   ii. Prompt Pay Reports [as specified in the Fiscal Performance Appendix (Appendix J)]

   iii. Cost Reports [as specified in the Fiscal Performance Appendix (Appendix J)]

   iv. Care Management Data [as specified in the Data Quality Appendix (Appendix L)]

   v. HEDIS IDSS Data/FAR [as specified in the Data Quality Appendix (Appendix L)]

   vi. CAHPS Data [as specified in the Data Quality Appendix (Appendix L)]

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

   i. The MCP's Chief Executive Officer;

ii. The MCP's Chief Financial Officer,

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

MCPs must provide certification as to the accuracy, completeness, and truthfulness of additional submissions.

3. Pursuant to 42 CFR 455.20, MCPs must have a method for verifying with enrollees whether services billed by providers were received. Therefore, the MCP is required to conduct a mailing of Explanation of Benefits (EOBs) to a 95% confidence level (plus or minus 5 percent margin of error) random sample of the MCP's enrollees once a year. As an option, the MCP may meet this requirement by using a strategy targeting services or areas of concern as long as the number of mailed EOBs is not less than the number generated by the random sample described above. Any MCP opting to use a targeted mailing must submit the proposed strategy in writing to ODM, and receive written prior approval from ODM. The EOB mailing must only include those members that have received health care services within the last six months, comply with all state and federal regulations regarding release of personal health information, outline the recent medical services identified as having been provided to the enrollee, and request that the enrollee report any discrepancies to the MCP. MCPs must inform their Contract Administrator of the date of the EOB mailing and provide results of the mailing 60 to 90 days after the mailing (i.e., number mailed, number of enrollees reporting discrepancies).

4. Breaches of Protected Health Information: MCPs must report the number of breaches of protected health information (PHI) and specify how many breaches were reported to HHS as required by 45 CFR Part 164.408 (b) and (c). This report must be submitted annually as indicated on the "MCP Calendar of Required Submissions."

5. **Credible Allegation of Fraud**: MCPs must promptly refer suspected cases of fraud to ODM for investigations and determination of whether a credible allegation of fraud exists as required in 1e of this appendix. If a credible allegation of fraud exists, at the direction of ODM, all payments must be immediately suspended, and the provider must be suspended in accordance with Ohio Rev. Code 5164.36.

APPENDIX J

FINANCIAL PERFORMANCE

1. SUBMISSION OF FINANCIAL STATEMENTS AND REPORTS

MCPs must submit the following financial reports to the Ohio Department of Medicaid (ODM):

a. The National Association of Insurance Commissioners (NAIC) quarterly and annual Health Statements (hereafter referred to as the "Financial Statements"), as outlined in OAC rule 5160-26-09(B). The Financial Statements must include all required Health Statement filings, schedules and exhibits as stated in the NAIC Annual Health Statement Instructions including, but not limited to, the following sections: Assets, Liabilities, Capital and Surplus Account, Cash Flow, Analysis of Operations by Lines of Business, Five-Year Historical Data, and the Exhibit of Premiums, Enrollment and Utilization and the Modified Supplemental Health Care Exhibit. The Financial Statements must be submitted to ODM even if the Ohio Department of Insurance (ODI) does not require the MCP to submit these statements to ODI. An electronic copy of the reports in the NAIC-approved format must be provided to ODM;

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

c. Annual audited Financial Statements prepared by a licensed independent external auditor as submitted to the ODI, as outlined in OAC rule 5160-26-09(B);

d. Quarterly and Annual Medicaid MCP ODM Cost Reports for all covered populations specified in Appendix B of this Agreement and the auditor's certification of the cost report, as outlined in OAC rule 5160-26-09(B);

e. Annual physician incentive plan disclosure statements and disclosure of and changes to the MCP's physician incentive plans, as outlined in OAC rule 5160-26-09(B);

f. Reinsurance agreements, as outlined in OAC rule 5160-26-09(C);

g. Prompt Pay Reports, in accordance with OAC rule 5160-26-09(B). An electronic copy of the reports in the ODM-specified format must be provided to ODM;

h. Notification of requests for information and copies of information released pursuant to a tort action (i.e., third party recovery), as outlined in OAC rule 5160-26-09.1;

i. Financial, utilization, and statistical reports, when ODM requests such reports, based on a concern regarding the MCP's quality of care, delivery of services, fiscal operations or solvency, in accordance with OAC rule 5160-26-06(D);

j. MCPs must submit ODM-specified reports for the calculation of items 2.b, 2.c and 2.d below in electronic formats.

Penalty for noncompliance: Noncompliance with submission of the above items will result in penalties, as outlined in Appendix N of the Provider Agreement.

2. FINANCIAL PERFORMANCE MEASURES AND STANDARDS

This Appendix establishes specific expectations concerning the financial performance of MCPs. In the interest of administrative simplicity and non-duplication of areas of ODI authority, ODM's emphasis is on the assurance of access to and quality of care. ODM will focus only on a limited number of indicators and related standards to monitor MCP financial performance. The five indicators and standards for this Agreement period are identified below. The source for each indicator will be the NAIC Quarterly and Annual Financial Statements and Modified Supplemental Health Care Exhibit. The measurement period that will be used to determine compliance will be the annual Financial Statement and Modified Supplemental Health Care Exhibit.

a. **Indicator: Current Ratio**

Please refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Current Ratio.

Standard: The Current Ratio must not fall below 1.00 as determined from the annual Financial Statement submitted to ODI and ODM.

b. **Indicator: Medical Loss Ratio**

Please refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Medical Loss Ratio indicator.

Standard: Minimum Medical Loss Ratio must not fall below 85%, as determined from the annual Modified Supplemental Health Care Exhibit of the annual Financial Statement submitted to ODM.

c. **Indicator: Administrative Expense Ratio**

Please refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Administration Expense Ratio indicator.

Standard: Administrative Expense Ratio must not exceed 15%, as determined from the annual Financial Statement submitted to ODI and ODM.

d. **Indicator: Overall Expense Ratio**

Please refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Overall Expense Ratio indicator.

Standard: Overall Expense Ratio must not exceed 100% as determined from the annual Financial Statement submitted to ODI and ODM.

e. **Indicator: Defensive Interval**

Please refer to the ODM Methods for Financial Performance Measures for the definition and calculations for the Defensive Interval indicator.

Standard: The Defensive Interval must not fall below 30 days as determined from the annual Financial Statement submitted to ODI and ODM.

Penalty for noncompliance: Noncompliance with the above standards (a. through e.) will result in penalties, as outlined in Appendix N of this Provider Agreement.

Long-term investments that can be liquidated without significant penalty within 24 hours, which an MCP includes in cash and short-term investments in the financial performance measures, must be disclosed in footnotes on the NAIC Reports. Descriptions and amounts must also be disclosed. Please note that "significant penalty" for this purpose is any penalty greater than 20%. The MCP must enter the amortized cost of the investment, the market value of the investment, and the amount of the penalty.

3. REINSURANCE REQUIREMENTS

Pursuant to the provisions of OAC rule 5160-26-09(C), the MCP must carry reinsurance coverage from a licensed commercial carrier to protect against inpatient-related medical expenses incurred by Medicaid members.

The annual deductible or retention amount for such insurance must be specified in the reinsurance agreement and must not exceed $100,000.00, unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement. Except for transplant services, and as provided below, this reinsurance must cover, at a minimum, 80% of inpatient costs incurred by one member in one year, in excess of $100,000.00 unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement.

For transplant services, the reinsurance must cover, at a minimum, 50% of inpatient transplant related costs incurred by one member in one year, in excess of $100,000.00 unless ODM has provided the MCP with prior approval in writing for a higher deductible amount or alternate reinsurance arrangement.

An MCP may request a higher deductible amount and/or that the reinsurance cover less than 80% of inpatient costs in excess of the deductible amount, only after the MCP has one year of enrollment in Ohio. If the MCP does not have more than 75,000 members in Ohio, but does have more than 75,000 members between Ohio and other states, ODM may consider alternate reinsurance arrangements. However, depending on the corporate structures of the Medicaid MCP, other forms of security may be required in addition to reinsurance. These other security tools may include parental guarantees, letters of credit, or performance bonds. In determining whether or not the request will be approved, ODM may consider any or all of the following:

a. Whether the MCP has sufficient reserves available to pay unexpected claims;

b. The MCP's history in complying with financial indicators 2.a., 2.b., 2.c. 2.d and 2.e, as specified in this Appendix;

c. The number of members covered by the MCP;

d. How long the MCP has been covering Medicaid or other members on a full risk basis;

e. Risk based capital ratio greater than 2.5 or higher calculated from the last annual ODI financial statement;

f. Scatter diagram or bar graph from the last calendar year that shows the number of reinsurance claims that exceeded the current reinsurance deductible graph/chart showing the claims history for reinsurance above the previously approved deductible from the last calendar year.

Penalty for noncompliance: Noncompliance with submission of the above items will result in penalties, as outlined in Appendix N of the Provider Agreement.

4. PROMPT PAY REQUIREMENTS

In accordance with 42 CFR 447.46, MCPs must pay 90% of all submitted clean claims within 30 days of the date of receipt and 99% of such claims within 90 days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule that is mutually agreed upon and described in their contract. The clean pharmacy and non-pharmacy claims will be separately measured against the 30 and 90 day prompt pay standards. The prompt pay requirement applies to the processing of both

electronic and paper claims for contracting and non-contracting providers by the MCP and delegated claims processing entities.

The date of receipt is the date the MCP receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or date of electronic payment transmission. A claim means a bill from a provider for health care services that is assigned a unique identifier. A claim does not include an encounter form.

A "claim" can include any of the following: (1) a bill for services; (2) a line item of services; or (3) all services for one recipient within a bill. A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

Clean claims do not include payments made to a provider of service or a third party where the timing of the payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Penalty for noncompliance: Noncompliance with submission of the above items will result in penalties, as outlined in Appendix N of the Provider Agreement.

5. PHYSICIAN INCENTIVE PLAN DISCLOSURE REQUIREMENTS

MCPs must comply with the physician incentive plan requirements stipulated in 42 CFR 438.6(h)**.** If the MCP operates a physician incentive plan, no specific payment can be made directly or indirectly under this physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

If the physician incentive plan places a physician or physician group at substantial financial risk [as determined under paragraph (d) of 42 CFR 422.208] for services that the physician or physician group does not furnish itself, the MCP must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with paragraph (f) of 42 CFR 422.208, and conduct periodic surveys in accordance with paragraph (h) of 42 CFR 422.208.

In accordance with 42 CFR 417.479 and 42 CFR 422.210, MCPs must maintain copies of the following required documentation and submit to ODM upon request:

a. A description of the types of physician incentive arrangements the MCP has in place which indicates whether they involve a withhold, bonus, capitation, or other arrangement. If a physician incentive arrangement involves a withhold or bonus, the percent of the withhold or bonus must be specified.

b. A description of information/data feedback to a physician/group on their: 1) adherence to evidence-based practice guidelines; and 2) positive and/or negative care variances from standard clinical pathways that may impact outcomes or costs. The feedback information may be used by the MCP for activities such as physician performance improvement projects that include incentive programs or the development of quality improvement initiatives.

c. A description of the panel size for each physician incentive plan. If patients are pooled, then the pooling method used to determine if substantial financial risk exists must also be specified.

d. If more than 25% of the total potential payment of a physician/group is at risk for referral services, the MCP must maintain a copy of the results of the required patient satisfaction survey and documentation verifying that the physician or physician group has adequate stop-loss protection, including the type of coverage (e.g., per member per year, aggregate), the threshold amounts, and any coinsurance required for amounts over the threshold.

Upon request by a member or a potential member and no later than 14 calendar days after the request, the MCP must provide the following information to the member: (1) whether the MCP uses a physician incentive plan that affects the use of referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of the survey results if the MCP was required to conduct a survey. The information provided by the MCP must adequately address the member's request.

6. NOTIFICATION OF REGULATORY ACTION

Any MCP notified by the ODI of proposed or implemented regulatory action must report such notification and the nature of the action to ODM no later than one working day after receipt from ODI. The ODM may request, and the MCP must provide, any additional information as necessary to assure continued satisfaction of program requirements. MCPs may request that information related to such actions be considered proprietary in accordance with established ODM procedures. Failure to comply with this provision will result in an immediate enrollment freeze.

APPENDIX K

QUALITY CARE

This Appendix establishes program requirements and expectations related to the Managed Care Plan's (MCP's) responsibilities for developing and implementing health, prevention, and wellness programs; performing care coordination activities; developing and implementing a Quality Assessment and Performance Improvement program; and participating in external quality review activities. These program requirements support the priorities and goals set forth in the Ohio Medicaid Quality Strategy.

1. Health and Wellness Programs

   a. MCPs are required to develop health, prevention, and wellness programs that are designed to promote the use of evidence-based clinical practices and appropriate health service utilization. The MCP must design programs that include the following elements:

      1.a.i. Identification of members who are at risk for developing a disease and/or who inappropriately utilize health care services. The MCP must implement mechanisms to identify such members through the following sources, as applicable: administrative data review (e.g., pharmacy claims, emergency department claims, or inpatient hospital admissions), provider/member referrals, telephone interviews, home visits, referrals resulting from internal MCP operations, and information as reported by the Medicaid Consumer Hotline during membership selection.

      1.a.ii. Provision for education, outreach or other targeted initiatives (e.g., incentive programs) to each member identified in 1.a to help the member maintain his/her health and wellness. The MCP must also enable the member to make informed decisions about accessing and utilizing health care services appropriately.

      The MCP must inform providers of the programs which are available to members, and enable providers to refer members to the programs.

   b. Enhanced Maternal Care Program

      The MCP must implement an approach to maternal care that encompasses a continuum of care starting at preconception and spans the spectrum of reproductive health services. The MCP's maternal care programs should be designed to improve birth outcomes, reduce infant mortality, and optimize health outcomes for the woman and infant. At a minimum, the MCP's program must target women, as described below, with a high risk pregnancy or women who are at risk for a poor pregnancy or poor birth outcome due to a prior poor birth outcome or preterm birth, and/or complex medical condition or social/behavioral risk factors:

i. Prenatal care: The MCP must implement mechanisms to improve the timely identification of women with high risk pregnancies. Acceptable identification mechanisms include, but are not limited to, pregnancy risk assessments, physician referrals, and data from the Ohio Department of Health's vital statistics system as provided by ODM. The MCP's identification strategy must result in the detection of high risk pregnant women with prior preterm births or poor birth outcomes (defined as fetal, neonatal or infant deaths) and/or who have high risk medical conditions (e.g., diabetes, hypertension, depression). The MCP must implement strategies (e.g., centering/group care, tobacco cessation programs, progesterone therapies, antenatal steroids) that are in effect during a woman's pregnancy, are evidence-based, adhere to clinical guidelines, and are individualized based on the needs of the woman.

ii. Inter-conception care: The MCP must implement mechanisms (e.g., data from the Ohio Department of Health's vital statistics system) to improve the identification of women of childbearing age who are at risk of a poor pregnancy or poor birth outcome due to a prior preterm birth or a poor birth outcome. The MCP must implement inter-conception care strategies (e.g., tobacco cessation, nutrition counseling, family planning counseling) that are in effect between the end of one pregnancy and the beginning of the next pregnancy, are evidence based, adhere to clinical guidelines, are individualized based on the needs of the woman, and are aimed at improving the outcomes of the woman's next pregnancy.

iii. The MCP is required to submit the enhanced maternal care program as prescribed by ODM for approval.

2. Care Coordination Activities

Managed Care Plans are required to perform care coordination activities that eliminate fragmentation in the care delivery system, promote clear communication, and ensure that patients and providers have access to information in order to optimize care. Care coordination activities include but are not limited to the following components:

2.a. Establishment of a primary care provider (PCP) for each member and encouragement of the member to maintain an ongoing relationship with the PCP. The MCP must ensure the PCP agrees to perform the care coordination responsibilities as outlined in OAC 5160-26-03.1.

2.b. Provision for members, specifically those with special health care needs, to directly access a specialist (e.g., for an approved number of visits or a standing referral) as appropriate for the member's condition and health care needs. The MCP must inform members identified with a special health care need of their right to directly access a specialist.

2.c. Support the Ohio Department of Medicaid's (ODM) efforts to promote the patient centered medical home (PCMH) model. The following are examples of how this can be accomplished: 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.

2.d. Participation in, and support of, ODM's efforts to develop the health homes model as defined by the following services: comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, individual and family support, referral to community and social support services, and the use of health information technology to link services.

, Community mental health centers (CMHCs) certified by the Ohio Department of Mental Health and Addiction Services (MHA) may apply to become Medicaid Health Home providers. Approved Medicaid Health Home providers will provide Health Home services to individuals with serious and persistent mental illness (SPMI). Health Home services consist of the following components: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, referrals to community and social support services, and the use of health information technology to link health home activities. Health Home services will be available to individuals with SPMI who are enrolled in a MCP. ODM will contract with the approved CMHC Health Home for the provision of, and payment for, Health Home services.

The MCP will play a critical role in supporting the CMHC Health Home to ensure all of its members receiving Health Home services have their needs met. The MCP will be required to perform the tasks specified below in order to support the CMHC Health Home and the delivery of Health Home services:

2.d.i. Within either four weeks of the CMHC receiving approval by the State to be a Health Home or prior to the CMHC Health Home providing Health Home services to the MCP's members, the MCP must establish a partnership with each CMHC Health Home and develop written policies and procedures that address the following components:

2.d.i.a. delineation of the responsibilities of the CMHC Health Home and the MCP in providing the Health Home services and supports, respectively, in order to avoid duplication or gaps in services. In collaboration with the CMHC, the MCP may provide Health Home supports, such as assistance with arranging transportation, scheduling appointments, facilitating transitions of care, providing education to the member, lending plan staff to serve as clinical consultants/resources to the core CMHC Health Home team, etc.

2.d.i.b. identification of a single point of contact for each CMHC Health Home who shall work with the CMHC Health Home on activities such as the following: participating on the CMHC Health Home's Care Management Team (i.e., CMHC Health Home core team, member, family/supports, primary care provider, specialists, the managed care plan, etc.), collaborating on the development of the assessment and the care plan, facilitating data exchange with the CMHC Health Home, etc.

2.d.i.c. transmission of data, information, and reports to the CMHC Health Home.

Unless otherwise indicated, the data, information and reports must be provided to the CMHC Health Home within 30 calendar days of the date the MCP is notified that a member is receiving Health Home services. A routine data exchange schedule should be established and based on a frequency agreed to by the CMHC Health Home and the MCP. At a minimum, the following data, information and reports, as applicable, shall be provided to the CMHC Health Home:

1. The most recent assessment, care plan, and progress notes for any member who is either currently enrolled in the MCP's care management program or was discharged from the MCP's care management program within the three months prior to the Health Home services start date;
2. Approved prior authorizations for future services (e.g., inpatient facility stays);
3. Same day notification of recent/upcoming admissions and discharges for an inpatient facility stay or emergency department visit;
4. Clinical patient summaries (including diagnosis and medication profiles);
5. Summaries of member contacts with the 24/7 nurse advice line, care management department, or the member services line that pertain to the delivery or receipt of Health Home services for a member;
6. Enrollment of the member in the plan's Coordinated Services Program;
7. Grievances (as defined in 5160-26-08.4) related to Health Home services; or
8. Other data, information or reports as agreed upon by the CMHC Health Home and the MCP.

2.d.i.d. providing the CMHC Health Home with a list of contracted primary care providers, inpatient facilities, and specialists who may provide services to the plan's members who are receiving Health Home services. The MCP must also educate the CMHC Health Home about provider credentialing requirements in the event any of the CMHC Health Home's partnering providers are interested in contracting with the MCP; and

2.d.i.e. identification of the CMHC's partnering primary care providers. These partnering primary care providers may be co-located with the CMHC Health Home, directly owned by the CMHC Health Home, or in a referral and coordination relationship with the CMHC Health Home. The MCP must then

use its best efforts to contract with CMHC Health Home partnering primary care providers who may not currently be a part of the plan's panel of providers.

2.d.ii. Within 5 business days of being notified that a member is receiving Health Home services, the MCP must contact the CMHC Health Home to:

2.d.ii.a. confirm the start date for Health Home services;

2.d.ii.b. identify the member's primary care provider, as selected by the member or that the MCP and CMHC Health Home agree is the best option to deliver primary care for the member. If the primary care provider is not currently contracted with the MCP, the MCP must use its best efforts to contract with the primary care provider in order to promote continuity of care;

2.d.ii.c. identify a single point of contact as specified in 2.d.i.b;

2.d.ii.d. identify the data/information that will be transferred from the MCP to the CMHC Health Home as specified in 2.d.i.c; and

2.d.ii.e. collaboratively develop a transition plan for members in order to prevent unnecessary duplication of, or gaps in, services.
The duration of the transition period will depend on the CMHC Health Home's start date of operation. Within the first three months of the CMHC Health Home's start date, the transition period must be concluded within ninety (90) days of the date the MCP is informed by ODM that a member is receiving Health Home services. Beyond the initial three months, the transition period must be concluded within thirty (30) days of the date the MCP is informed by ODM that a member is receiving Health Home services.

2.d.iii. On a routine basis, the MCP must:

2.d.iii.a. perform ongoing identification of members who have a diagnosis of SPMI and who could benefit from receiving Health Home services;

2.d.iii.b. contact members identified in iii.a, educate the members about the benefits of Health Home services, assist the members in selecting a CMHC Health Home, and then facilitate the referral of the members to the selected CMHC Health Home;

2.d.iii.c. establish and maintain a mechanism to track the plan's members who are receiving Health Home services;

2.d.iii.d. integrate all information/data transmitted by the CMHC or ODM related to a member receiving Health Home services into any appropriate system or database that is maintained by the MCP, including member assessments, care management notes, discharge plans, care plans, etc.;

2.d.iii.e. participate in comprehensive transitional care activities with the CMHC Health Home for members who are discharged from, or

transferred between, care settings and which may include discharge planning, primary care provider follow up, medication reconciliation, and timely provision of post discharge services (e.g., durable medical equipment);

2.d.iii.f. integrate the results from the Health Homes' metrics into the plan's overall quality improvement program; and

2.d.iii.g. participate in the Medicaid Health Homes Learning Community which will consist of the CMHC Health Homes, the Ohio Department of Mental Health, the MCPs and ODM.

2.d.iv. The MCP may submit a member who is receiving Health Home services to the Care Management System (CAMS). This member will also be included in the care management program evaluation measures specified in section 2.h.ii.2.f. of this Appendix. The MCP must demonstrate that it is supporting the CMHC Health Home in the care management of that member. Therefore, prior to submitting a member to CAMS, the MCP must: 1) participate in one CMHC Health Home Care Management Team meeting; and 2) receive a copy of the care plan developed by the CMHC and integrate the plan into the MCP's system. In order to maintain an open enrollment span for the member in CAMS, the MCP must demonstrate that it has collaborated on at least a quarterly basis with the CMHC Health Home (e.g., re-evaluation of the member's needs, revision to the member's care plan, etc.). If an MCP does not meet these requirements for any member receiving Health Home services, then the MCP will be required to close the enrollment span for that member in CAMS.

2.d.v. The requirements established in Appendix K.2.g and K.2.h do not apply to MCP members who are receiving health home services.

2.e Assurance of a single point of care management for a member. ODM recognizes that a member may receive care management from multiple entities which can create fragmentation in the delivery system and duplication of services. The MCP is in an optimal position to review the member's health care needs and determine the entity (e.g., MCP, community based entity, or health home) that is most appropriate to manage and coordinate the member's health care needs. The goal is to avoid duplication of efforts and maximize efficiencies in the care delivery system.

2.f Implementation of Utilization Management Programs with clearly defined structures and processes to maximize the effectiveness of the care provided to members pursuant to OAC rule 5160-26-03.1(A)(7).

2.f.i. Drug Utilization Management - Pursuant to ORC Sec. 5167.12, MCPs may implement strategies for the management of drug utilization.

MCPs may, subject to ODM prior-approval, require PA of certain drug classes and place limitations on the type of provider and locations where certain drugs may be

administered. MCPs must establish their PA system so that it does not unnecessarily impede member access to medically-necessary Medicaid-covered services as follows:

a. As outlined in paragraph 31.g. of Appendix C, MCPs must adhere to specific PA limitations to assist with the transition of new members from FFS Medicaid.

b. As outlined in paragraph 2.b.vi of Appendix G, MCPs must allow members to receive without PA certain antidepressant and antipsychotic drugs and to take into consideration if the member is stabilized on a specific antidepressant or antipsychotic drug when PA is permitted.

c. MCPs must comply with the provisions of 1927(d)(5) of the Social Security Act, 42 USC 1396r-8(d)(k), and OAC rule 5160-26-03.1 regarding the timeframes for prior authorization of covered outpatient drugs.

MCPs must develop and submit for prior approval, a coordinated services program as defined in OAC rule 5160-20-01 to address the utilization or pattern of receiving medications at a frequency or in an amount that exceeds medical necessity. MCPs must also develop retrospective drug utilization review programs designed to promote the appropriate clinical prescribing of covered drugs. MCPs must also provide care management services to any member who is enrolled in the coordinated services program.

2.f.ii. Emergency Department Diversion (EDD) – MCPs must provide access to services in a way that assures access to primary, specialist and urgent care in the most appropriate settings and that minimizes frequent, preventable utilization of emergency department (ED) services. OAC rule 5160-26-03.1(A)(7)(d) requires MCPs to implement the ODM-required EDD program for frequent utilizers.

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

It is important to ensure that a member's frequent ED utilization is not due to problems such as their PCP's lack of accessibility or failure to make appropriate specialist referrals. The MCP's EDD program must therefore also include the identification of providers who serve as PCPs for a substantial number of frequent ED utilizers and the implementation of corrective action with these providers as so indicated.

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

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

2.f.iii. Other UM Programs – MCPs may develop other UM programs, subject to prior approval by ODM. For the purposes of this requirement, UM programs which require ODM prior-approval are any other program designed by the MCP with the purpose of redirecting or restricting access to a particular service or service location.

2.g. -Transitions of Care

2.g.i The MCP must effectively and comprehensively manage transitions of care between settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The MCP must at a minimum:

a. identify members who require assistance transitioning between care settings;
b. develop a method for evaluating risk of readmission in order to determine the intensity and urgency of follow up that is required for the member after the date of discharge;
c. designate MCP staff who will regularly communicate with the discharging facility and inform the facility of the designated MCP contacts;
d. ensure that timely notification and receipt of admission dates, discharge dates and clinical information is communicated between internal MCP departments and between care settings, as appropriate;
e. participate in discharge planning activities with the facility including making arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCP;
f. obtain a copy of the discharge/transition plan;
g. arrange for services specified in the discharge/transition plan; and
h. conduct timely follow up with the member and member's providers to ensure post discharge services have been provided.

When an MCP is contacted by an inpatient facility for an MCP's member, who is not identified in 2.g.i.a and 2.g.i.b, with a request for assistance with discharge planning, the MCP must initiate and implement steps 2.g.i.c – h, as applicable, to ensure adequate discharge planning occurs for the member.

The MCP must ensure that the transition/discharge plan and post-discharge services are integrated into the member's care plan.

Upon request, the MCP may be required to submit the transition of care strategy as prescribed by ODM for approval.

2.g.ii Transition of Care from the Ohio Department of Rehabilitation and Correction's Facilities to the Community for Critical Risk Individuals

The MCP is responsible for facilitating and managing transitions of care for pending members who are designated as critical risk, according to ODM's definition, and are being discharged from Ohio Department of Rehabilitation and Correction's (ODRC's) facilities. Upon receiving notification from ODM and/or ODRC about pending members who will be released from the ODRC facility and will be enrolled with the MCP, the MCP will identify which pending members meet the critical risk criteria. For pending members confirmed as meeting the critical risk criteria, the MCP will receive clinical information from ODRC and other entities. The MCP may request additional information for these pending members from the ODRC facility using the process prescribed by ODM. The MCP will notify ODRC if the requested records are not received within the timeframes established by ODRC & ODM.

The MCP must develop a transition plan using the approved ODM form with information provided by ODRC and other programs/entities (e.g., Ohio Department of Mental Health and Addiction Services' Community Linkages program). The MCP must facilitate input to the transition plan by entities specified by ODM. The MCP will conduct an interactive session (e.g., videoconference) to review the completed transition plan with each pending member who meets the critical risk criteria. The MCP will request the interactive session and submit a copy of the transition plan to the ODRC facility according to the methods and timeframes prescribed by ODM. This interactive session must occur at least fourteen (14) calendar days prior to the pending member's scheduled release date from the ODRC facility. The MCP must review the transition plan with the pending member during the interactive session and identify/confirm necessary changes that will be made to the transition plan. The MCP must update the transition plan, as appropriate, and submit the final transition plan to ODRC/Operations Support Center and the ODRC facility as prescribed by ODM.

After the pending member is released from the ODRC facility, the MCP must contact the member as expeditiously as the member's condition warrants but not later than five (5) calendar days to assist the member with accessing care according to the transition plan, including identifying and removing barriers to care, and addressing additional needs that are expressed by the member. If the MCP is unable to contact the member- within the first five calendar days (i.e., three different attempts over the 5 days), the MCP must send a letter to the member no later than seven calendar days from the release date which includes contact information for member services and the care management department in order to request assistance with accessing services or community supports. The MCP must document all outreach attempts and contacts with the member.

The MCP must assess the member's need for care management using processes established in 2.h.

The MCP will report metrics as specified below to ODM for members who were released from an ODRC facility, met the critical risk criteria and are now enrolled with the MCP:

1. Monthly reports: The MCP must report the following information on a monthly basis for critical risk individuals who are enrolled with the MCP:
    a. The total number of members who met the chronic risk criteria;
    b. The total number of members reported in a. who had a transition plan developed by the MCP prior to release from the ODRC facility;
    c. The total number of members reported in b. who the MCP contacted within five calendar days of the release date from the ODRC facility;
    d. The total number of members reported in b. for whom the MCP was unable to contact within the five calendar days and who were sent a letter by the MCP;
    e. The total number of members (reported in a.) for whom the MCP assessed for any level of care management;
    f. The total number of members (reported in a.) for whom the MCP did not assess and the reasons why (refused, unable to reach, unable to contact); and
    g. The total number of members who were assessed (reported in e.) and enrolled in care management by stratification level (high, complex, medium, and low).

   Monthly reports will be due to ODM on the 10th calendar day of each month and will include data for members who were enrolled with the MCP during the prior calendar month.

2. Quarterly reports: The MCP must report the following information on a quarterly basis for critical risk individuals:
    a. The total number of members who met the critical risk criteria and had a Serious Mental Illness designation (C1 per the ODRC definition), and of those who had a follow up visit with a Community Mental Health Center within 30 days and 31-60 days of the release date from the ODRC facility.
    b. The total number of members who met the critical risk criteria and had recovery services level of care (R3 per the ODRC definition), and of those who had a follow up visit with a qualified provider within 30 days of the release date of the facility.
    c. The total number of SMI members who met the critical risk criteria and had any prescription filled within 30 days and 31-60 days of the release date from the ODRC facility.

Quarterly reports due in SFY 2016 must be submitted in accordance with the following due dates:

- The report due on September 10, 2015 will include any critical risk members who
  were enrolled in the MCP from April 1 through June 30, 2015.

- The report due on December 10, 2015 will include any critical risk members who were enrolled in the MCP from July 1, 2015 through September 30, 2015.

- The report due on March 10, 2016 will include critical risk members who were enrolled in the MCP from October 1, 2015 through December 31, 2015.

- The report due on June 10, 2016 will include any critical risk members who were enrolled in the MCP from January 1, 2016 through March 31, 2016.

The MCP will be required to report additional metrics according to the specifications and timeframes established by ODM.

The MCP will implement a method to identify and track all current members who were released from the ODRC facility and enrolled with the MCP.

2.h. Each MCP must implement a Care Management Program as outlined below which coordinates and monitors the care for members with complex needs. The MCP must consider the Case Management Society of America's *Standards of Practice for Case Management, 2010* when designing and implementing its care management program.

2.h.i In accordance with OAC 5160-26-03.1(A)(8), the managed care plan must offer and provide care management services which coordinate and monitor the care for members with complex needs.

2.h.ii. Members who are eligible for care management have varying needs and require differing levels of interventions. Therefore, the MCP must design its care management program using risk stratification levels (e.g., low, medium, complex or high) which then determine the intensity of interventions and follow up care that is required for each member enrolled in the care management program. At a minimum, the MCP must use three stratification levels as part of its care management program that range from low risk to high risk; one of the levels must correspond to the high risk stratification level as specified below. The MCP will be afforded flexibility in the structuring of the care management program for the low, medium or complex risk stratification levels. ODM will set forth explicit requirements for the high risk stratification level.

2.h.ii.a. For low, medium or complex risk stratification levels, the MCP must ensure the following functions are incorporated in to the care management program and plan operations:

2.h.ii.a.1. Identification strategy: The MCP must implement mechanisms to identify members eligible for care management services.

2.h.ii.a.2. Risk Stratification level: The MCP must develop a strategy to assign a member to a low, medium or complex risk stratification level based on the results of the identification and/or assessment processes. The risk level shall be adjusted by the MCP based on the completion of the assessment and the member's demonstrated progress in meeting the goals established in the care plan.

2.h.ii.a.3. Assessment: The MCP must conduct, or arrange for, an assessment of the following domains: physical, behavioral, and psychosocial needs. The goal of the assessment is to determine the appropriate level of care management for the member. Assessments must be updated when there is a change in the member's health status, needs or a significant health care event.

2.h.ii.a.4. Care plan: The MCP must develop a care plan for the member based on the assessment that incorporates prioritized goals, interventions, and outcomes with timeframes for completion, which must include, at a minimum, the following:

1. Assessment and documentation of the member's progress in achieving goals and outcomes established in the care plan;
2. Coordination of care for the member with the appropriate primary care provider, specialists, and/or other providers, as needed;
3. Completion of a care gap analysis between recommended care and actual care received, and revision to the care plan when gaps in care or a change in health status or need is identified;
4. Collaboration with the member, provider, and others on any updates to the care plan; and,
5. Updates to the care plan as expeditiously as the member's needs warrant but no later than 14 calendar days from the date the change in need is identified.

The MCP must allow the member, the member's family, the member's designee and providers to provide input into the care plan. Care plans must be made available to members and providers upon request.

2.h.ii.a.5. Care manager/care management team: The MCP must assign an accountable point of contact (i.e., care manager) for each member. The MCP must use a multidisciplinary team, when appropriate, to provide care management services for the member based on his/her needs. All members of the team are responsible for applying a person/family centered approach to care management and communicating information about the member to the member's accountable point of contact.

2.h.ii.a.6. Interaction with the member: The MCP must develop and document a communication plan in the MCP's care management system that is based on the

member's needs and includes a provision for two-way communication between the MCP and the member.

2.h.ii.b. For the high risk stratification level, the MCP must ensure the following functions are incorporated in to the care management program and plan operations:

2.h.ii.b.1. Identification strategy: The MCP must include the following components:

i. Use of an industry-standard predictive model
ii. A means to target costly members
iii. A health risk assessment tool
iv. Physician referrals
v. Consumer referrals

ODM encourages the MCP to integrate the results of the health risk assessment tool in to the predictive model. The plan must integrate the above components in to the overall strategy to identify members for whom the plan can have the greatest impact on health outcomes and cost.

2.h.ii.b.2. Assessment: The MCP must complete an assessment that is comprehensive and evaluates the following domains: the member's physical, functional, behavioral (i.e., mental health and substance abuse disorders), social and psychological needs; medical and behavioral health history including diagnoses, treatments and service utilization; individual's preferences, goals and desired level of involvement in the care planning process; discharge and/or transition plans; environmental/safety concerns; residential/care setting; self-care capabilities; readiness to change; barriers to accessing care, etc. The MCP must solicit input from the member, caregivers/family, the primary care provider, and other providers, as appropriate. The initial assessment shall be completed by the MCP within thirty calendar days of identifying the member's need for care management.

After the initial enrollment to the care management program, the MCP must update the assessment when there's been a change in health status, needs, or a significant health care event. If the MCP is unaware of any such changes, then the MCP must re-evaluate the member's needs on at least a quarterly basis. A comprehensive reassessment must be completed at least once every twelve (12) months after the completion of the initial comprehensive assessment.

2.h.ii.b.3. Care plan: The MCP must implement a person/family-centered care planning process that yields a single, individualized care plan for the member, is based on the comprehensive assessment, and includes the following elements:

i. Prioritized measureable goals, interventions and anticipated outcomes with completion timeframes that address the member's clinical and non-clinical needs.

ii. Process to develop, update and review the care plan (i.e., both initial and revised) with the member, the family/caregivers, and the primary care provider/specialist, and other providers, as appropriate. The MCP shall work with the member and providers to identify needs and opportunities for intervention.

iii. An aggressive strategy for effective and comprehensive transitions of care between care settings which includes obtaining discharge/transition plan; conducting timely follow up with the member and the member's providers; and arranging for services specified in the discharge/transition plan.

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

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

vi. Identification of the providers responsible for delivering services, identification of referrals made to specialists or providers, and confirmation that the member received the services.

vii. Implementation and monitoring of the care plan, that includes:

- Assessment and documentation of the member's progress in achieving goals and outcomes established in the care plan;
- Coordination of care for the member with the primary care provider, specialists, and other providers, as appropriate;
- Completion of a care gap analysis, at least once a quarter, between recommended care and actual care received, and revision to the care plan when gaps in care or a change in health status or need is identified;
- Collaboration with the member, provider, and others on the updates to the care plan; and,
- Updates to the care plan as expeditiously as the member's needs warrant but no later than 14 calendar days from the date the change in need is identified.

viii. A provision to refer the member, if applicable, to a community/social recovery support agency, assist the member in contacting the agency, and validate the member received the service.

ix. A provision to report feedback to the provider on member compliance with the care plan.

x. Continuous evaluation of the member's need for care management services as specified in 2.h.iii.f of this Appendix.

2.h.ii.b.4. Care Manager/Care Management Team: The MCP must assign an accountable point of contact for each member (i.e., care manager). The MCP must use a multidisciplinary team to provide care management services for the member that is appropriate for the member's needs. All members of the team are responsible for

applying a person/family centered approach to care management and communicating information about the member to the member's accountable point of contact.

The MCP is required to maintain a staffing ratio of one (1) full time equivalent (FTE) for every twenty-five (25) members enrolled in high risk care management. At a minimum, the MCP must ensure that the FTE count reported for each measurement period only includes: 1) a person's time (i.e., staff who are directly employed or subcontracted) who directly interacted with a member in high risk care management or who directly participated in the member's care plan (e.g., discharge planning, collaborative case conference); and 2) vendors and community partners for which the MCP has an ODM-approved delegation agreement.

ODM will assess plan compliance with the staffing ratio as specified in the *ODM Methods for the High Risk Care Management Staffing Ratio.* The minimum performance standard for the January-June 2015, July – December 2015, and January – June 2016 measurement periods will be one full time equivalent for every 25 members enrolled in high risk care management (or 0.040).

2.h.ii.b.5. Interaction with the member: The MCP must establish a contact schedule with the member that is based on his or her needs and facilitates on-going communication with the member. At a minimum, the MCP must complete one successful face-to-face contact with the member every 90 calendar days. The MCP will be granted a 7-day grace period for each required face-to-face contact. At least one of the in-person visits must be conducted within the first 6 months of enrollment in care management and then annually thereafter must be conducted by the MCP at the individual's residential setting, if allowed by the member. The MCP may use video communication (e.g., skype, facetime, video conference) that is HIPAA compliant as a means to conduct the face-to-face contact. The use of video communication is limited to one of the 90-day visits within a six-month period. The activity conducted during the face-to-face contact must be linked to the goals, interventions, and outcomes identified in the care plan and must be directed by the MCP care manager. The face-to-face contact should occur at a location that is agreed upon by the member and the MCP. The outcome of the face-to-face visit should be documented, reported back to the MCP care manager, and integrated in to the plan of care. Upon request, the MCP must provide a copy of the contact schedule to the member.

2.h.ii.b.6.i Care Management Program evaluation measures:

i. Care Management of High Risk Members.
Measure: The percent of members in the MCP that are care managed at a high risk stratification level.
SFY 2014 Measurement Periods: January 1, 2014 through June 30, 2014.

SFY 2015 Measurement Periods: July 1, 2014 through December 31, 2014 and January 1, 2015 through June 30, 2015.
SFY 2016 Measurement Periods: July 1, 2015 through December 31, 2015 and January 1, 2016 through June 30, 2016
Minimum Performance Standard: 1.0%.

ii. Overall Medical Costs of Members in High Risk Care Management
Measure: The change in overall medical costs of the MCP members who are in high risk care management.
SFY 2014 Measurement Periods: January 1, 2014 through June 30, 2014.
SFY 2015 Measurement Periods: July 1, 2014 through December 31, 2014 and January 1, 2015 through June 30, 2015.
SFY 2016 Measurement Periods: July 1, 2015 through December 31, 2015 and January 1, 2016 through June 30, 2016.
Minimum Performance Standard: The overall medical costs of the members in high risk care management must decrease.

iii. Emergency Department Utilization Rate of Members in High Risk Care Management
Measure: The change in the emergency department utilization rate of the MCP members who are in high risk care management.
SFY 2014 Measurement Periods: January 1, 2014 through June 30, 2014.
SFY 2015 Measurement Periods: July 1, 2014 through December 31, 2014 and January 1, 2015 through June 30, 2015.
SFY 2016 Measurement Periods: July 1, 2015 through December 31, 2015 and January 1, 2016 through June 30, 2016.

Minimum Performance Standard: The emergency department utilization rate of the members in high risk care management must decrease.

iv. Inpatient Hospitalization Rate of Members in High Risk Care Management
Measure: The change in the inpatient hospitalization rate of the MCP members who are in high risk care management.
SFY 2014 Measurement Periods: January 1, 2014 through June 30, 2014.
SFY 2015 Measurement Periods: July 1, 2014 through December 31, 2014 and January 1, 2015 through June 30, 2015.
SFY 2016 Measurement Periods: July 1, 2015 through December 31, 2015 and January 1, 2016 through June 30, 2016.

Minimum Performance Standard: The inpatient hospitalization rate of the members in high risk care management must decrease.

Penalties for non-compliance with the care management program evaluation measures are listed in Appendix N.

2.h.ii.b.6.ii Measures and Measurement Periods

ODM reserves the right to revise the measures and measurement periods established in this Appendix (and their corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's performance level for that contract period.

2.h.ii.b.6.iii Performance Standards – Compliance Determination

In the event an MCP's performance cannot be evaluated for a care management program evaluation measure and measurement period established in this appendix, ODM in its sole discretion will deem the MCP to have met or to have not met the standard(s) for that particular measure and measurement period depending on the circumstances involved.

2.h.iii. The MCP is expected to address the following components in the overall care management program structure (i.e., apply to all risk stratification levels):

2.h.iii.a. The MCP must inform all members and contracting providers of the MCP's care management services.

2.h.iii.b. The MCP is responsible for ensuring that staff who are completing care management functions are operating within their professional scope of practice, are appropriate for responding to the member's health care needs, and follow the state's licensure/credentialing requirements.

2.h.iii.c. The MCP's care manager and/or the care management team are expected to conduct the following activities for each member enrolled in care management:

i. Help the member obtain medically necessary care;
ii. Assist with health related services;
iii. Coordinate care for the member with the primary care provider, specialists, and other care managers;
iv. Disseminate information to the member concerning the health condition types of services that may be available and how to access the services; and
v. Implement and monitor the care plan

2.h.iii.d. Members under the age of 21 who have an Individualized Education Program (IEP) may also be receiving care management services from an MCP. A parent or school district may contact the MCP and request MCP participation in the IEP meetings. Upon request, the MCP must participate in the IEP meeting for those individuals who are currently receiving care management services from the MCP. As a result, the MCP shall consider the individual's IEP when developing or updating the care plan.

2.h.iii.e. A member must be enrolled in the MCP's care management program within 90 calendar days of identifying the member's need for care management. This includes the care management activities of identification of the member's need for care management, completion of the assessment, and development of the care plan.

2.h.iii.f. The MCP must develop a strategy that continuously evaluates a member's ongoing need for care management and aims to either transition the member out of the care management program or to a different risk stratification level. The MCP should identify the reason(s) for changing the member's care management status (e.g., achieving goals in the care plan, member declines participation in care management, etc.); discuss the proposed action with the member and the primary care provider, as appropriate; provide reasonable notice about the change in the care management status to the member and the provider; revise the communication plan, if necessary; and issue a written communication to the member regarding the change in the care management status.

2.h.iii.g. The MCP may implement an "opt out" process for members in the low, medium and complex risk stratification levels. An opt out process allows the MCP to automatically enroll a member in the care management program until the member declines the offer to participate. For members assigned to a high risk stratification level, the MCP must obtain verbal or written confirmation from the member that he/she understands the enrollment in the care management program.

2.h.iii.h. The MCP must apply evidence based guidelines or best practices when developing and implementing care management interventions.

2.h.iii.i. The MCP must have a care management tracking system that captures, at a minimum, for each member the results of the assessment and the care plan content, including the measureable goals, interventions, outcomes and completion dates. This system must be linked to other databases or systems that the MCP uses to maintain information about the member. The goal is to integrate the member information in a meaningful way to facilitate care management needs. Upon request by the member or the provider, the system(s) must contain the capability to share care management information with the member, the PCP, and specialists.

2.h.iii.j. The MCP must identify community, social, and recovery support services that are available at the county level and develop a resource guide which contains a listing of the support service agencies and contact information that is easily accessible by care managers, members, and providers. The resource guide must be updated as new contacts are identified by the MCP. The MCP is encouraged to collaborate with other MCPs in the service area to develop a unified approach to contact and partner with community service agencies.

2.h.iii.k. The MCP must submit a monthly electronic file to the Care Management System (CAMS) for all members who are provided care management services as specified in the *ODM Care Management File and Submission Specifications.* For an MCP to submit a member as being care managed to CAMS, the MCP must first perform the activities of identification, completion of the assessment and development of the care plan. ODM, or the external quality review organization, will validate the accuracy of the information contained in the CAMS with the member's care management record.

2.h.iii.l. The MCP must develop and implement a strategy to routinely evaluate the effectiveness and impact of the MCP's overall care management program with regard to health outcomes, consumer satisfaction, quality of life, inpatient hospital utilization rates, emergency department utilization rates, and medical costs, etc. The MCP must produce results for the overall program and by each stratification level. Results must be available to ODM upon request. The MCP must use the evaluation results to make enhancements, as necessary, to the care management program.

2.h.iii.m. The MCP must attest that care managers and MCP employed/delegated members of the care management team are not related by blood or marriage to the member or any paid caregiver, financially responsible for the member, or empowered to make financial or health related decisions on behalf of a member.

2.h.iii.n. The MCP must employ a methodology for assigning consistent and appropriate caseloads for care managers that assures health, welfare and safety for members. The MCP must incorporate the following factors into its caseload assignment methodology:

- population;
- acuity status mix;
- care manager qualifications, years of experience, and responsibilities;
- provision of support staff;
- location of care manager (community, MCP office, provider office);
- geographic proximity of care manager to members (if community based); and
- access to and capabilities of technology/IT systems.

The MCP must ensure there is a method to periodically evaluate caseload assignments, including identification of circumstances that automatically trigger a review/adjustment of caseload sizes. The MCP must submit a description of the methodology to ODM as specified and when requested.

2.h.iii.o. The MCP must submit a description of the care management program as specified by ODM on an annual basis. This documentation is subject to a review and audit by ODM and the external quality review organization as specified by ODM.

3. Quality Assessment and Performance Improvement Program

The MCP must administer its Medicaid line of business in an efficient and effective manner while maintaining an organizational focus on quality and continuous learning.

As required by 42 CFR 438.240, each MCP must develop a Quality Assessment and Performance Improvement (QAPI) Program that reflects a systematic approach for assessing and improving the quality of care. The QAPI program must be submitted on an annual basis to ODM and must include the following elements:

3a. Performance Improvement Projects and Quality Improvement Projects (PIPs and QIPs)

i. Performance Improvement Projects

In accordance with federal requirements, each MCP must conduct clinical and non-clinical performance improvement projects (PIPs) using quality improvement science techniques that are designed to achieve, through frequent measurement and intervention, improvements in health outcomes, quality of life and satisfaction for providers and consumers. The MCP must adhere to ODM-specified reporting, submission and frequency guidelines. The MCP must initiate and complete PIPs in topics selected by ODM. All PIPs designed and implemented by the MCP must be approved by ODM.

The external quality review organization (EQRO) will assist MCPs with the development and implementation of PIPs by providing technical assistance, and will annually validate the PIPs in accordance with the Centers for Medicare and Medicaid Services' protocols.

ii. Quality Improvement Projects

Quality Improvement Projects (QIPs) are projects required by the state or initiated by the MCP that use quality improvement science principles. Like PIPs, the QIPs can focus on clinical or non-clinical areas, are intended to achieve significant and sustained improvement over time, and have favorable effects on health outcomes, quality of life and provider/consumer satisfaction. QIPs are not validated by the EQRO. The MCP must adhere to ODM-specified reporting and submission requirements.

iii. The MCP shall actively participate in performance and quality improvement projects that are facilitated by ODM or the EQRO, or both. This includes but is not limited to:

- attending meetings;
- assigning MCP staff to the PIP or QIP efforts who are subject matter experts in the PIP or QIP topic, are familiar with MCP policies and processes related to the topic and who have decision making authority;
- responding promptly to data requests;
- dedicating resources to implement quality improvement interventions;
- establishing internal mechanisms to frequently communicate PIP or QIP status updates and results to the MCP's Medical Director and the Quality Improvement Director; and
- maintaining regular communication with ODM or EQRO staff.

MCP Medical Directors, Quality Improvement Directors, and at least one MCP staff person assigned to PIP/QIP teams will be required to complete a one-time accredited/certified education course in quality improvement science. Medical Directors and QI Directors must submit evidence of course completion by June 30, 2015. At least one MCP staff person participating in each QIP/PIP project must complete an accredited/certified education course by December 31, 2015. Staff will be exempt from this requirement if one of the following conditions is met: 1) an accredited/certified education course in quality improvement science has been completed since July 1, 2013; or 2) satisfactory completion of CPHQ certification after January 1, 2015. Medical Directors and Quality Improvement Directors who are hired after January 1, 2015, must complete the course within six (6) months of their start date unless they have evidence of course completion within the two year prior to their effective start date.

iv. The MCP shall integrate results from performance and quality improvement projects into its overall quality assessment and improvement program.

3b. Assessment of Health Care Service Utilization

Each MCP must have mechanisms in place to detect under- and over-utilization of health care services. The MCP must specify the mechanisms used to monitor utilization in the annual submission of the QAPI program to ODM. The MCP must ensure the utilization analysis documented in the QAPI is linked to the strategies employed by the MCP for the Health, Wellness, and Prevention programs and the Utilization Management programs sections of this Appendix.

It should also be noted that pursuant to the program integrity provisions outlined in Appendix I, the MCP must monitor for the potential under-utilization of services by its members in order to assure that all Medicaid-covered services are being provided, as

required. If any underutilized services are identified, the MCP must immediately investigate and correct the problem(s) which resulted in such underutilization of services.

In addition, the MCP must conduct an ongoing review of service denials and must monitor utilization on an ongoing basis in order to identify services which may be underutilized.

3c. Assessment of the Quality and Appropriateness of Care for Members with Special Health Care Needs

Each MCP must have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. The MCP must specify the mechanisms used in the annual submission of the QAPI program to ODM.

3d. Submission of Performance Measurement Data

Each MCP must submit data as required by ODM that enables ODM to calculate standard measures as defined in Appendix M.

Each MCP must also submit self-reported, audited Healthcare Effectiveness Data and Information Set (HEDIS) data (see *ODM Methodology for MCP Self-Reported, HEDIS-Audited Data*) for performance measures set forth in Appendix M.

3e. Quality Measurement Assessment and Improvement Strategy

The MCP must measure, analyze, and track performance indicators which reflect Ohio Medicaid's Quality Strategy clinical focus areas (e.g., behavioral health, high-risk pregnancy/premature births) and other quality initiatives (e.g., high risk care management, emergency department diversion programs) in place to advance the goals of the Quality Strategy. The MCP must include all Provider Agreement measures in Appendices K and M as part of this effort but may also include other measures (e.g., NCQA accreditation set) that assist the MCP in advancing the goals of the Quality Strategy.

The MCP's quality measurement assessment and improvement strategy must include the following activities:

i. Establishing a measureable goal and benchmark for each performance indicator;
ii. Measuring performance and comparing the rate for each indicator to the established goal and benchmark;
iii. Reviewing data trends to detect improvement, decline or stability in the rates at a frequency no less often than quarterly;
iv. Identifying any opportunities for improvement;
v. Conducting a root cause analysis to identify factors that may impact the adequacy of rates;

vi. Developing and implementing quality improvement interventions, using a rapid cycle improvement approach, that will address the root cause of the deficiency; and

vii. Developing a plan to monitor the quality improvement interventions to detect if the changes are an improvement.

The MCP must ensure that these activities are linked to the MCP's annual evaluation of the impact and effectiveness of its QAPI program. Upon request, the MCP must make the performance indicator tracking and reporting mechanisms and any quality improvement work plans available for review by ODM.

3f. Addressing Health Disparities

The MCP must participate in, and support, ODM's efforts to eliminate health disparities in Ohio. The U.S. Department of Health and Human Services – Centers for Disease Control and Prevention defines health disparities as "differences in health outcomes and their determinants as defined by social, demographic, geographic, and environmental attributes."

The MCP will be required to participate in a Health Equity Workgroup (HEW) which will, at a minimum, be comprised of representatives from each MCP, ODM, Ohio Commission on Minority Health, and the Ohio Department of Health. The HEW will be charged with characterizing the extent of healthcare disparities among health plan members by establishing common health disparity measures and developing a strategy to address disparities revealed by the results of the measures. When establishing disparity measures, the workgroup will determine the data elements (e.g., self-identified race, ethnicity, and language) needed to calculate the health disparity measures. MCPs will collect the data elements and calculate the results of the measures to inform the development of the strategy.

3g. Impact and Effectiveness of the QAPI Program

Each MCP must evaluate the impact and effectiveness of the QAPI program. The MCP must update the QAPI program based on the findings of the self-evaluation and submit annually to ODM for review and approval.

3h. Accountability for the QAPI Program

Each MCP must establish appropriate administrative oversight arrangements and accountability for the QAPI program which includes the following: assignment of a senior official responsible for the QAPI program (e.g., Quality Improvement Director, Medical Director); provision for ongoing communication and coordination between the area that oversees the QAPI program and relevant functional areas of the organization; assurance that the Medical Director is involved in all clinically related projects; and that staff

responsible for implementation of the QAPI program have the appropriate education, experience and training.

4. External Quality Review

ODM will select an external quality review organization (EQRO) to provide for an annual, external, and independent review of the quality, outcomes, timeliness of and access to services provided by MCPs. The MCP must participate in annual external quality review which will include but not be limited to the following activities:

4.a. Administrative compliance assessment as required by 42 CFR 438.358 and as specified by ODM.

4.a.i. Non duplication exemption – As allowed by 42 CFR 438.360 and 438.362, an MCP with accreditation from a national organization approved by the Centers for Medicare and Medicaid services may request to be exempted from certain portions of the administrative compliance assessment. ODM will inform the MCP when a non-duplication exemption may be requested.

4.a.ii. The EQRO may conduct focused reviews of MCP performance in the following domains which include, but are not limited to:

1. Availability of services
2. Assurance of adequate capacity and services
3. Coordination and continuity of care
4. Coverage and authorization of services
5. Credentialing and recredentialing of services
6. Sub contractual relationships and delegation
7. Enrollee information and enrollee rights
8. Confidentiality of health information
9. Enrollment and disenrollment
10. Grievance process
11. Practice guidelines
12. Quality assessment and performance improvement program
13. Health information systems
14. Fraud and abuse

4.b. Encounter data studies
4.c. Validation of performance measurement data
4.d. Review of information systems
4.e. Validation of performance improvement projects
4.f. Member satisfaction and/or quality of life surveys

The MCP must submit data and information, including member medical records, at no cost to, and as requested by ODM or its designee for the annual external quality review.

The penalties for non-compliance with external quality review activities are listed in Appendix N, Compliance Assessment System.

APPENDIX L

DATA QUALITY

A high level of performance on the data quality standards and requirements established in this appendix is crucial in order for the Ohio Department of Medicaid (ODM) to determine the value of the Medicaid Managed Health Care Program and to evaluate Medicaid consumers' access to and quality of services. Data collected from MCPs are used in key performance assessments such as the external quality review, clinical performance measures, utilization review, care coordination and care management, and in determining incentives. The data will also be used in conjunction with the cost reports in setting the premium payment rates. Data sets collected from MCPs with data quality standards 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, and third party liability data.

The measures in this Appendix are calculated per MCP using statewide results that include all regions in which the MCP has membership. Unless otherwise specified, each measure is calculated for the MCP's overall Ohio Medicaid population (i.e., ABD, CFC, and Adult Extension members).

ODM reserves the right to revise the measures and measurement periods established in this appendix (and their corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's performance level for that contract period.

1. ENCOUNTER DATA

For detailed descriptions of the encounter data quality measures below, see *ODM Methods for the CFC and ABD Encounter Data Quality Measures*.

Each MCP's encounter data submissions will be assessed for completeness and accuracy. The MCP is responsible for collecting information from providers and reporting the data to ODM in accordance with program requirements established in Appendix C, *MCP Responsibilities*. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with other performance standards.

1.a. Encounter Data Completeness

1.a.i. Encounter Data Volume

This measure is calculated separately for ABD adults, ABD children, CFC members (adults and children combined), and Adult Extension members.

Measure: The volume measure for each population and service category, as listed in Table 2 of this appendix, is the rate of utilization (e.g., discharges, visits) per 1,000 member months (MM).

Measurement Period: The measurement periods for each population for the State Fiscal Year (SFY) 2015 and SFY 2016 contract periods are listed in Table 1 below. Note: For ABD adults and CFC members, the pharmacy service category was reporting only beginning with measurement period Q1 2010 through measurement period Q3 2011.

Table 1. Measurement Periods for the SFY 2015 and SFY 2016 Contract Periods

CFC Quarterly Measurement Periods	ABD Adult Quarterly Measurement Periods	ABD Child Quarterly Measurement Periods	Adult Extension Members Quarterly Measurement Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 2 thru Qtr 4: 2011, Qtr 1 thru Qtr 4: 2012, 2013, Qtr 1 2014	Qtr 2 thru Qtr 4: 2011, Qtr 1 thru Qtr 4: 2012, 2013, Qtr 1 2014	Qtr 3, Qtr 4: 2013, Qtr 1 2014	Qtr 1 2014	September 2014	October 2014	SFY 2015
Qtr 3, Qtr 4: 2011, Qtr 1 thru Qtr 4: 2012, 2013, Qtr 1, Qtr 2: 2014	Qtr 3, Qtr 4: 2011, Qtr 1 thru Qtr 4: 2012, 2013, Qtr 1, Qtr 2: 2014	Qtr 3, Qtr 4: 2013, Qtr 1, Qtr 2: 2014	Qtr 1, Qtr 2: 2014	October 2014	November 2014	
Qtr 4: 2011, Qtr 1 thru Qtr 4: 2012, 2013, Qtr 1 thru Qtr 3: 2014	**Qtr 4: 2011, Qtr 1 thru Qtr 4: 2012, 2013, Qtr 1 thru Qtr 3: 2014**	**Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 3: 2014**	Qtr 1 thru Qtr 3: 2014	January 2015	February 2015	
Qtr 1 thru Qtr 4: 2012, 2013, 2014	Qtr 1 thru Qtr 4: 2012, 2013, 2014	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014	Qtr 1 thru Qtr 4: 2014	April 2015	May 2015	
Qtr 2 thru Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1 2015	Qtr 2 thru Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1 2015	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, Qtr 1 2015	Qtr 1 thru Qtr 4: 2014, Qtr 1 2015	July 2015	August 2015	SFY 2016

Qtr 3, Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1, Qtr 2: 2015	Qtr 3, Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1, Qtr 2: 2015	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, Qtr 1, Qtr 2: 2015	Qtr 1 thru Qtr 4: 2014, Qtr 1, Qtr 2: 2015	October 2015	November 2015	
Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1 thru Qtr 3: 2015	Qtr 4: 2012, Qtr 1 thru Qtr 4: 2013, 2014, Qtr 1 thru Qtr 3: 2015	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, Qtr 1, thru Qtr 3: 2015	Qtr 1 thru Qtr 4: 2014, Qtr 1 thru Qtr 3: 2015	January 2016	February 2016	
Qtr 1 thru Qtr 4: 2013, 2014, 2015	Qtr 1 thru Qtr 4: 2013, 2014, 2015	Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 4: 2014, 2015	Qtr 1 thru Qtr 4: 2014, 2015	April 2016	May 2016	

Qtr 1 = January to March; Qtr 2 = April to June; Qtr 3 = July to September; Qtr 4 = October to December

Data Quality Standards: The data quality standards, per population and service category, are listed in Table 2 below. This measure is calculated separately for each population. For each population, MCPs must meet or exceed the standard for every service category.

Note: MCPs will be held accountable to the data quality standards for this measure beginning with the 'Qtr 4: 2011, Qtr 1 thru Qtr 4: 2012, 2013, and Qtr 1 thru Qtr 3: 2014' measurement period for the CFC and ABD Adult populations, and with the 'Qtr 3, Qtr 4: 2013, Qtr 1 thru Qtr 3: 2014' measurement period for the ABD Child population (as bolded in Table 1 above). The reports issued prior to these measurement periods for these populations will be informational. Data quality standards and measurement periods for which the MCPs will be held accountable for the Adult Extension population are to be determined, and are estimated to be released, by SFY 2017.

Table 2. Data Quality Standards

Category	Measure per 1,000/MM	CFC Standards	ABD Adult Standards	ABD Child Standards	Adult Extension Standards	Description
Inpatient Hospital	Discharges	4.6	22.0	4.6	TBD	General/acute care, excluding newborns and mental health and chemical dependency services

Emergency Department	Visits	61.6	135.0	61.6	TBD	Includes physician and hospital emergency department encounters
Dental		34.0	28.1	34.0	TBD	Non-institutional and hospital dental visits
Vision		11.6	19.2	7.7	TBD	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		267.5	452.0	234.7	TBD	Physician/practitioner and hospital outpatient visits
Behavioral Health	Service	16.0	75.5	16.0	TBD	Inpatient and outpatient behavioral encounters
Pharmacy*	Prescrip-tions	579.9	4260.4	579.9	TBD	Prescribed drugs

*For CFC and ABD adult reports issued on and after August 2010: MCPs will be held accountable for this measure in the pharmacy service category for measurement periods prior to Q1 2010 and after Q3 2011. Measurement periods Q1 2010 through Q3 2011 were reporting only for the pharmacy service category.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standards for this measure.

1.a.ii. Incomplete Rendering Provider Data - *(effective SFY 2016)*

The *Incomplete Rendering Provider Data* measure is calculated to ensure that MCPs are reporting individual-level rendering provider information to ODM so that Ohio Medicaid complies with federal reporting requirements.

Measure: The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in MITS.

Measurement Period: The measurement periods for the SFY 2015 and SFY 2016 contract periods are listed in Table 3. below. SFY 2015 results are reporting only and will be used as a baseline to set a data quality standard for SFY 2016. MCPs will be held accountable to the data quality standard for this measure beginning SFY 2016.

Table 3. Measurement Periods for the SFY 2015 and SFY 2016 Contract Periods

Quarterly Measurement Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1 thru Qtr 4: 2013; Qtr 1 thru Qtr 3: 2014	January 2015	February 2015	SFY 2015
Qtr 1 thru Qtr 4: 2013; Qtr 1 thru Qtr 4: 2014	April 2015	May 2015	
Qtr 1 thru Qtr 4: 2014; Qtr 1: 2015	July 2015	August 2015	SFY 2016
Qtr 1 thru Qtr 4: 2014; Qtr 1, Qtr 2: 2015	October 2015	November 2015	
Qtr 1 thru Qtr 4: 2014; Qtr 1 thru Qtr 3: 2015	January 2016	February 2016	
Qtr 1 thru Qtr 4: 2014; Qtr 1 thru Qtr 4: 2015	April 2016	May 2016	

Qtr 1 = January-March; Qtr 2 = April-June; Qtr 3 = July-September; Qtr 4 = October-December

Data Quality Standard: (effective SFY 2016) – >3.0%

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standard for this measure.

1.a.iii. NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers - *(effective SFY 2016)*

The *NPI Provider Number Usage without Medicaid/Reporting Provider Numbers* measure is calculated to ensure that providers reported on encounters can be associated with Medicaid and/or Reporting providers in MITS.

Measure: The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data field that do not have a NPI and Medicaid or Reporting Provider Number in MITS.

Measurement Period: The measurement periods for the SFY 2015 and SFY 2016 contract periods are listed in Table 3. above. SFY 2015 results are reporting only and will be used as a baseline to set a data quality standard for SFY 2016. MCPs will be held accountable to the data quality standard for this measure beginning SFY 2016.

Data Quality Standard: (effective SFY 2016) – >4.4%

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standard for this measure.

1.a.iv. Rejected Encounters

Encounters submitted to ODM that are incomplete or inaccurate are rejected and reported back to the MCPs on the Exception Report. If an MCP does not resubmit rejected encounters, ODM's encounter data set will be incomplete.

1) Measure 1 - Measure 1 only applies to MCPs that have had Medicaid membership for more than one year.

Measure 1: The percentage of encounters submitted to ODM that are rejected

Measurement Period: For the SFY 2016 contract period, performance will be evaluated using the following measurement periods: July – September 2015; October – December 2015; January – March 2016; and April – June 2016.

Results from September 2011 through September 2012 were used as a baseline to set a data quality standard for this measure.

MCPs will be held accountable to the data quality standard set for this measure effective with the January – March 2015 measurement period.

Data Quality Standard for measure 1: The data quality standard for measure 1 is a maximum encounter data rejection rate for each file type in the ODM-specified medium per format as follows:

837 Dental:	23%
837 Institutional:	22%
837 Professional:	34%
NCPDP:	19%

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standard for this measure.

2) Measure 2 - Measure 2 only applies to MCPs that have had Medicaid membership for one year or less.

Measure 2: The percentage of encounters submitted to ODM that are rejected

Measurement Period: The measurement period for Measure 2 is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment. This measure will not be calculated for SFY 2016.

Data Quality Standard for measure 2: The data quality standard for measure 2 is a maximum encounter data rejection rate for each file type in the ODM-specified medium per format as follows:

Third through sixth month with membership: Not Applicable for SFY 2016
Seventh through twelfth month with membership: Not Applicable for SFY 2016

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with the standard for this measure.

1.a.v. Acceptance Rate

This measure only applies to MCPs that have had Medicaid membership for one year or less.

Measure: The rate of encounters that are submitted to ODM and accepted (i.e. accepted encounters per 1,000 member months).

Measurement Period: The measurement period for this measure is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment. This measure will not be calculated for SFY 2016.

Data Quality Standard: The data quality standard is a monthly minimum accepted rate of encounters for each file type in the ODM-specified medium per format as follows:

Third through sixth month with membership: Not Applicable for SFY 2016
Seventh through twelfth month of membership: Not Applicable for SFY 2016

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with the standards for this measure.

1.b. Encounter Data Accuracy

1.b.i. Encounter Data Accuracy Studies

As with data completeness, MCPs are responsible for assuring the collection and submission of accurate data to ODM. Failure to do so jeopardizes MCPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

Measure 1 (This measure is calculated for CFC and Adult Extension members only): The focus of this accuracy study will be on delivery encounters. Its primary purpose will be to verify that MCPs submit encounter data accurately and to ensure only one payment is made per delivery. The rate of appropriate payments will be determined by comparing a sample of delivery payments to the medical record.

Measurement Period: In order to provide timely feedback on the accuracy rate of encounters, the measurement period will be the most recent from when the measure is initiated. This measure is conducted annually.

Medical records retrieval from the provider and submittal to ODM or its designee is an integral component of the validation process. ODM has optimized the sampling to minimize the number of records required. This methodology requires a high record submittal rate. To aid MCPs in achieving a high submittal rate, ODM will give at least an 8 week period to retrieve and submit medical records as a part of the validation process. A record submittal rate will be calculated as a percentage of all records requested for the study.

Data Quality Standard 1 for Measure 1: For results that are finalized during the contract year, the accuracy rate for encounters generating delivery payments is 100%.

Data Quality Standard 2 for Measure 1: A minimum record submittal rate of 85%.

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with the standards for this measure.

Measure 2: This accuracy study will compare the accuracy and completeness of payment data stored in MCPs' claims systems during the study period to payment data submitted to and accepted by ODM. Two levels of analysis will be conducted: one to evaluate encounter data completeness for which two rates will be calculated and one to evaluate payment data accuracy. Payment completeness and accuracy rates will be determined by aggregating data across claim types (i.e., professional, pharmacy, and institutional) and stratifying data by file type (i.e., header and detail).

Encounter Data Completeness (Level 1):
Omission Encounter Rate: The percentage of encounters in an MCP's fully adjudicated claims file not present in the ODM encounter data files.

Surplus Encounter Rate: The percentage of encounters in the ODM encounter data files not present in an MCP's fully adjudicated claims files.

Payment Data Accuracy (Level 2):
Payment Error Rate: The percentage of matched encounters between the ODM encounter data files and an MCP's fully adjudicated claims files where a payment amount discrepancy was identified.

Measurement Period: In order to provide timely feedback on the omission rate of encounters, the measurement period will be the most recent from when the study is initiated. This study is conducted annually.

Data Quality Standard for Measure 2:

For SFY 2015 and SFY 2016:
For Level 1: An omission encounter rate and a surplus encounter rate of no more than 11% for both claim-level and line-level records.
For Level 2: A payment error rate of no more than 4%.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standard for this measure.

1.b.ii. Encounter Data Payments Compared to Managed Care Cost Report Information

This measure is calculated separately for the ABD, CFC, and Adult Extension populations.

Measure: The difference between the MCP payment amount as reported on the encounter data and on the Managed Care Cost Reports, as a percentage of the total cost reported on the Managed Care Cost Reports, by category of service and rate cell as aggregated in Tables 5. and 6. below.

Measurement Period: The measurement periods for the SFY 2016 and SFY 2017 contract periods are listed in Table 4. below.

Table 4. Measurement Periods for the SFY 2016 and SFY 2017 Contract Periods

Quarterly Measurement Periods	Encounter Data File Update	Quarterly Report Estimated Issue Date
SFY 2016 Contract Period		
Qtr1: 2015	June 2015	June 2015
Qtr2: 2015	September 2015	September 2015
Qtr3: 2015	December 2015	December 2015
Qtr4: 2015	March 2016	March 2016
SFY 2017 Contract Period		
Qtr1: 2016	June 2016	June 2016
Qtr2: 2016	September 2016	September 2016
Qtr3: 2016	December 2016	December 2016
Qtr4: 2016	March 2017	March 2017

Qtr 1 = January to March; Qtr 2 = April to June; Qtr 3 = July to September; Qtr 4 = October to December

Data Quality Standards: The data quality standards, per population and category of service, are listed in Table 5. below. This measure is calculated separately for each population. For each population, MCPs must meet the standard for every category of service. SFY 2016 results are

informational only. MCPs will be held accountable to the data quality standards for this measure beginning SFY 2017.

Table 5. Data Quality Standards

Category of Service	CFC Standards	ABD Standards	Adult Extension Standards	Managed Care Cost Report Categories of Service
Inpatient	TBD	TBD	TBD	Categories of Service 01, 02, 04, 06, and 07
Outpatient	TBD	TBD	TBD	Categories of Service 08-13
Emergency	TBD	TBD	TBD	Categories of Service 14-21
Professional	TBD	TBD	TBD	Categories of Service 22-30
Dental	TBD	TBD	TBD	Category of Service 38
Pharmacy	TBD	TBD	TBD	Category of Service 37
Other	TBD	TBD	TBD	Categories of Service 31-36, and 39-44

*Excludes shadow-priced encounters and sub-capitated costs reported on the Managed Care Cost Reports.

Table 6. Population Rollups by Rate Cell

Populations	Managed Care Cost Report Rate Cell
ABD	RC19 and RC20
CFC	RC01 to RC09
Extension	RC11 to RC18

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with the standards for this measure.

1.c. Encounter Data Submission

Information concerning the proper submission of encounter data may be obtained from the *ODM Encounter Data Submission Specifications* document. Note, the *ODM Encounter Data Submission Specifications* include: encounter data companion guides for institutional, professional, and dental 837 EDI transactions, NCPDP D.0 files, 824 Application Advice, and 277 Unsolicited Claim/Encounter Status Notifications; *ODM Encounter Data Submission Guidelines*; *ODM Encounter Data Submission Schedule; Encounter Data Letter of Certification*; and *ODM Covered Families and Children Delivery Payment Reporting Procedures*. The encounter data companion guides must be used in conjunction with the X12 Implementation Guide for EDI transactions.

1.c.i. Encounter Data Submission Procedure

The MCP must submit encounter data files to ODM per the specified schedule and within the allotted amount established in the *ODM Encounter Data Submission Specifications.*

The MCP must submit a letter of certification, using the form required by ODM, with each encounter data file in the ODM-specified medium per format.

The letter of certification must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO (see *ODM Encounter Data Submission Specifications)*.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with these data submission requirements.

1.c.ii. Timeliness of Encounter Data Submission

ODM requires: MCP-paid encounters be submitted no later than thirty-five calendar days after the end of the month in which they were paid. Beginning in March 2015 for encounters paid in January 2015, MCPs must report encounter data submission lag time on a monthly basis to ODM. Results may be subject to an audit by ODM and/or its designee.

Effective with the September 2015 measurement period of SFY 2016, ODM will evaluate the timeliness of MCP paid encounters.

Measure: The percentage of the MCP's total monthly paid encounters that are submitted to ODM and accepted within 35 calendar days of the month in which they were paid,(e.g., encounters paid by the MCP in January 2015 that are submitted to ODM and accepted on or before March 7th 2015, divided by the total number of encounters paid by the MCP in January 2015).

Measurement Periods: For SFY 2015: January 2015, February 2015, March 2015, April 2015, May 2015, and June 2015. For SFY 2016: July 2015, August 2015, September 2015, October 2015, November 2015, December 2015, January 2016, February 2014, March 2016, April 2016, May 2016, and June 2016. SFY 2015 results are reporting only and will be used as a baseline to set the data quality standard for SFY 2016. January 2015 through August 2015 measurement periods are reporting only. MCPs will be held accountable to the data quality standard for this measure beginning with the September 2015 measurement period of SFY 2016.

Data Quality Standard: (effective with the September 2015 measurement period of SFY 2016) - TBD

The penalty for noncompliance with the standard(s) for this measure will be listed in Appendix N, *Compliance Assessment System*.

1.c.iii. Encounter Submissions Per Encounter Schedule

Measure: The percent of encounters listed on the Encounter Data Submission Schedule as the minimum amount for that month that were submitted to ODM and accepted.

Measurement Periods: For SFY 2015: January 2015, February 2015, March 2015, April 2015, May 2015, and June 2015. For SFY 2016, July 2015, August 2015, September 2015, October

2015, November 2015, December 2015, January 2016, February 2014, March 2016, April 2016, May 2016, and June 2016.

Data Quality Standard: The data quality standard is greater than or equal to 100%.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this data submission requirement.

2. MCP SELF-REPORTED, AUDITED HEDIS DATA

2.a. Annual Submission of HEDIS IDSS Data

MCPs are required to collect, report, and submit to ODM self-reported, audited HEDIS data (see *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*) for the full set of HEDIS measures reported by the MCP to NCQA for Ohio Medicaid members. This must include all HEDIS measures listed in Appendix M. The self-reported, audited HEDIS data are due to ODM no later than five business days after the NCQA due date.

HEDIS Measure Rotation
MCPs may not report rotated measure results, per NCQA methodology, for any HEDIS measure and measurement year listed in Table 1. and Table 2. of Appendix M.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this data submission requirement.

2.b. Annual Submission of Final HEDIS Audit Report (FAR)

MCPs are required to submit to ODM their FAR that contains the audited results for the full set of HEDIS measures reported by the MCP to NCQA for Ohio Medicaid members. This must include all HEDIS measures listed in Appendix M. The FAR is due to ODM no later than five business days after the NCQA due date (see *ODM Specifications for the Submission of MCP Self-Reported, Audited HEDIS Results*).

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this data submission requirement.

Note: ODM will review each MCP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. ODM reserves the right to pursue corrective action based on this review (see Appendix N, Section J.).

2.c. Data Certification Requirements for HEDIS IDSS Data and Final HEDIS Audit Report

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

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

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with these data submission requirements.

3. CARE MANAGEMENT DATA

ODM designed a Care Management System (CAMS) in order to monitor MCP compliance with program requirements specified in Appendix K.2.h.iii.j. Each MCP's care management data submission will be assessed for completeness and accuracy. The MCP is responsible for submitting a care management file every month. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with care management requirements. The MCP must also submit a letter of certification, using the form required by ODM, with each CAMS data submission file. The specifications for submitting the care management file and instructions for submitting the data certification letter are provided in the *ODM Care Management File and Submission Specifications*.

Timely Submission of Care Management Files

Data Quality Submission Requirement: The MCP must submit Care Management files on a monthly basis according to the specifications established in the *ODM Care Management Excel File and Submission Specifications.*

See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with this requirement.

4. APPEALS AND GRIEVANCES DATA

Pursuant to OAC rule 5160-26-08.4, MCPs are required to submit appeal and grievance activity to ODM as directed. ODM requires appeal and grievance activity to be submitted at least monthly in an electronic data file format pursuant to the *ODM Appeal File and Submission Specifications* and *ODM* G*rievance File and Submission Specifications*.

The appeal data file and the grievance data file must include all appeal and grievance activity, respectively, for the previous month, and must be submitted by the ODM-specified due date. These data files must be submitted in the ODM-specified format and with the ODM-specified filename in order to be successfully processed.

MCPs who fail to submit their monthly electronic data files to the ODM by the specified due date or who fail to resubmit, by no later than the end of that month, a file which meets the data quality requirements will be subject to penalty as stipulated under the Compliance Assessment System (Appendix N).

5. UTILIZATION MANAGEMENT DATA

Pursuant to OAC rule 5160-26-03.1, MCPs are required to submit information on prior authorization requests as directed by ODM. Effective January 2011, ODM requires information on prior authorization requests to be submitted at least bi-weekly in electronic data file formats pursuant to the *ODM Utilization Management Tracking Database: Prior Authorization File and Submission Specifications* document.

6. CAHPS DATA

6.a. Annual CAHPS Survey Administration and Data Submission

Each MCP is required to contract with an NCQA Certified HEDIS Survey Vendor to administer an annual CAHPS survey to the MCP's Ohio Medicaid members, per the survey administration requirements outlined in the *ODM CAHPS Survey Administration and Data Submission Specifications*. The survey data must be submitted to NCQA, The CAHPS Database, and ODM's designee per the data submission requirements and by the due dates established in the *ODM CAHPS Survey Administration and Data Submission Specifications*.

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with this requirement.

6.b. CAHPS Data Certification Requirements

Each MCP is required to annually submit to ODM three CAHPS data certification letters, one that attests to the MCP's adherence to ODM's requirements for the CAHPS survey administration and data submission to NCQA, a second that attests to the MCP's adherence to ODM's requirements for the CAHPS data submission to The CAHPS Database, and a third that attests to the MCP's adherence to ODM's requirements for the CAHPS data submission to ODM's designee. . The MCP's CAHPS data certification letters must be submitted per the instructions and by the due dates provided in the *ODM CAHPS Survey Administration and Data Submission Specifications.*

See Appendix N, *Compliance Assessment System*, for the penalties for noncompliance with these data submission requirements.

7. THIRD PARY LIABILITY DATA SUBMISSIONS

Beginning July 1, 2013, no later than the 20th of each month, MCPs must either (1) provide ODM with a Third Party Liability (TPL) data file that includes all TPL information for members

effective the first day of that month or (2) reconcile the ODM monthly TPL file with their data and provide ODM with a data file that contains any discrepancies, additions, and deletions. MCPs must submit this information electronically to ODM pursuant to the *ODM Third Party Liability File and Submission Specifications*.

APPENDIX M

QUALITY MEASURES AND STANDARDS

The Ohio Department of Medicaid (ODM) has established Quality Measures and Standards to evaluate Managed Care Plan (MCP) performance in key program areas (i.e., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and/or focus areas of the ODM Quality Strategy. Most measures have one or more Minimum Performance Standards. Specific measures and standards are used to determine MCP performance incentives, while others are used to determine MCP noncompliance sanctions. A limited number of measures are informational only and have no associated standards, incentives, or 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. Performance measures and standards are subject to change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as deemed relevant.

The establishment of Quality Measures and Standards in this Appendix is not intended to limit the assessment of other indicators of performance for quality improvement activities. Performance on multiple measures will be assessed and reported to the MCPs and others, including Medicaid consumers.

1. QUALITY MEASURES WITH STANDARDS

Minimum Performance Standards have been established for the clinical quality measures listed in Table 1. below. Specific measures are designated for use in the Pay-for-Performance (P4P) Incentive System each year (see Appendix O, *Pay-for-Performance (P4P)*). For these measures, performance exceeding the Minimum Performance Standard may result in the receipt of financial incentives for participating MCPs. For the remaining measures, failure to meet a Minimum Performance Standard will result in the assessment of a noncompliance penalty (see Appendix N, *Compliance Assessment System*).

MCPs are evaluated on each measure using statewide results that include all regions in which the MCP has membership. Results for each measure are calculated per MCP and include all of the MCP's Ohio Medicaid members who meet the criteria specified by the methodology for the given measure. MCP performance is assessed using ODM calculated performance measurement data for the CHIPRA and AHRQ measures, NCQA calculated summary rates for the HEDIS/CAHPS survey measures, and MCP self-reported, audited HEDIS data for the NCQA HEDIS measures listed in Table 1. below. The ODM methodology for the CHIPRA and AHRQ measures in Table 1. is posted, upon publication, to the *Medicaid Managed Care Program* page of the ODM website. The HEDIS measures and HEDIS/CAHPS survey measures in Table 1. are calculated in accordance with *NCQA's Volume 2: Technical Specifications* and *NCQA's Volume 3: Specifications for Survey Measures*, respectively. The previous calendar year is the standard measurement year for HEDIS data.

1.a. Measures, Measurement Sets, Standards, and Measurement Years

The measures and accompanying Minimum Performance Standards and measurement years for the SFY 2015, SFY 2016, and SFY 2017 contract periods are listed in Table 1. below. The measurement set associated with each measure is also provided. The measures used in the Pay for Performance (P4P) Incentive System each year are denoted with an asterisk (*) in the respective Minimum Performance Standard columns and the standard is bolded. The SFY 2015 contract period (measurement year CY 2014) will be reporting only for two measures introduced in SFY 2015. The SFY 2016 contract period (measurement year CY 2015) will be reporting only for the two measures introduced in SFY 2015 and four measures introduced in SFY 2016. No standard will be established or compliance assessed for the reporting only measures for SFY 2015 and SFY 2016, as applicable.

Table 1. SFY 2015, SFY 2016, and SFY 2017 Performance Measures, Measurements Sets, Standards, and Measurement Years

Quality Strategy Priority: Improve Care Coordination *Goal: Create a delivery system that is less fragmented, where communication is clear, and patients and clinicians have access to information in order to optimize care*										
Quality Strategy Focus Area	**Measure**	**Measure-ment Set**			**SFY 2015 Minimum Perf. Std.**	**SFY 2015 Measure-ment Year**	**SFY 2016 Minimum Perf. Std.**	**SFY 2016 Measure-ment Year**	**SFY 2017 Minimum Perf. Std.**	**SFY 2017 Measure-ment Year**
Access: Children's Access	Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months, 25 Months - 6 Years, 7-11 Years, and 12-19 Years	NCQA/ HEDIS			12-24Mos. ≥ 95.6%	CY 2014	12-24 Mos. ≥ 95.9%	CY 2015	12-24 Mos. TBD	CY 2016
					25 Mos.-6 Yrs. ≥ 86.7%		25 Mos.-6 Yrs. ≥ 86.1%		25 Mos. - 6 Yrs. TBD	
					7-11 Yrs. ≥ 87.6%		7-11 Yrs. ≥ 87.8%		7-11 Yrs. TBD	
					12-19 Yrs. ≥ 86.0%		12-19 Yrs. ≥ 85.8%		12-19 Yrs. TBD	
Access: Adults' Access	Adults' Access to Preventive/Ambulatory Health Services – Total	NCQA/ HEDIS			≥ 79.9%	CY 2014	≥ 80.7%	CY 2015	TBD	CY 2016
Quality Strategy Priority: Promote Evidence Based Prevention and Treatment Practices *Goal: Improve the health of priority populations*										

Quality Strategy Focus Area	Measure	Measure-ment Set			SFY 2015 Minimum Perf. Std.	SFY 2015 Measure-ment Year	SFY 2016 Minimum Perf. Std.	SFY 2016 Measure-ment Year	SFY 2017 Minimum Perf. Std.	SFY 2017 Measure-ment Year
Clinical Quality: Behavioral Health	Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up	NCQA/ HEDIS			**≥ 32.2%***	CY 2014	**≥ 31.7%***	CY 2015	**TBD***	CY 2016
Clinical Quality: Behavioral Health	Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	NCQA/ HEDIS			≥ 33.0%	CY 2014	Eliminated Effective SFY 2016	Eliminated Effective SFY 2016	Eliminated Effective SFY 2016	Eliminated Effective SFY 2016
Clinical Quality: Behavioral Health	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement of AOD Treatment, Total	NCQA/ HEDIS			≥ 5.8%	CY 2014	Eliminated Effective SFY 2016	Eliminated Effective SFY 2016	Eliminated Effective SFY 2016	Eliminated Effective SFY 2016
Clinical Quality: Behavioral Health	Adolescent Well-Care Visits	NCQA/ HEDIS			≥ 42.1%	CY 2014	**≥ 41.7%***	CY 2015	**TBD***	CY 2016
Clinical Quality: Behavioral Health	Metabolic Monitoring for Children and Adolescents on Antipsychotics, Total	NCQA/ HEDIS			Reporting only for SFY 2015	CY 2014	Reporting Only for SFY 2016	CY 2015	TBD	CY 2016
Clinical Quality: Behavioral Health	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total	NCQA/ HEDIS			Reporting only for SFY 2015	CY 2014	Reporting Only for SFY 2016	CY 2015	TBD	CY 2016
Clinical Quality: High Risk Pregnancy / Premature Births	Percent of Live Births Weighing Less Than 2,500 Grams	CHIPRA			≤ 9.5%	CY 2014	≤ 9.5%	CY 2015	TBD	CY 2016
Clinical Quality:										

High Risk Pregnancy / Premature Births	Prenatal and Postpartum Care - Timeliness of Prenatal Care	NCQA/ HEDIS			**≥ 80.5%***	CY 2014	**≥ 77.8%***	CY 2015	**TBD***	CY 2016
Clinical Quality: High Risk Pregnancy / Premature Births	Prenatal and Postpartum Care - Postpartum Care	NCQA/ HEDIS			≥ 58.7%	CY 2014	**≥ 56.2%***	CY 2015	**TBD***	CY 2016
Clinical Quality: High Risk Pregnancy / Premature Births	Frequency of Ongoing Prenatal Care – ≥ 81 Percent of Expected Visits	NCQA/ HEDIS			≥ 52.5%	CY 2014	≥ 43.7%	CY 2015	TBD	CY 2016
Clinical Quality: Asthma	Use of Appropriate Medications for People With Asthma – Total	NCQA/ HEDIS			**≥ 82.5%***	CY 2014	Eliminated Effective SFY 2016	Eliminated Effective SFY 2016	Eliminated Effective SFY 2016	Eliminated Effective SFY 2016
Clinical Quality: Asthma	Medication Management for People With Asthma – Medication Compliance 75 Percent, Total Rate	NCQA/ HEDIS	Not Applic-able	Not Applic -able	Not Applic-able	Not Applic-able	Not Applic-able	Not Applic-able	TBD	CY 2016
Clinical Quality: Asthma	PDI 14: Asthma Admission Rate (ages 2 - 17)	AHRQ			Not Applicable	Not Applic-able	Reporting Only for SFY 2016	CY 2015	TBD	CY 2016
Clinical Quality: Upper Respiratory Infections	Appropriate Treatment for Children With Upper Respiratory Infection	NCQA/ HEDIS			**≥ 80.6%***	CY 2014	**≥ 81.6%***	CY 2015	**TBD***	CY 2016
Clinical Quality:	Well-Child Visits in the First 15 Months of Life – Six or More Well-Child Visits	NCQA/ HEDIS								

Upper Respiratory Infections					≥ 54.3%	CY 2014	≥ 54.8%	CY 2015	TBD	CY 2016
Clinical Quality: Upper Respiratory Infections	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA/ HEDIS			≥ 65.5%	CY 2014	≥ 66.0%	CY 2015	TBD	CY 2016
Clinical Quality: Diabetes	Comprehensive Diabetes Care – HbA1c Control (<8.0%)	NCQA/ HEDIS			**≥ 42.1%***	CY 2014	**≥38.2%***	CY 2015	**TBD***	CY 2016
Clinical Quality: Diabetes	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	NCQA/ HEDIS			≥ 54.5%	CY 2014	≥ 53.7%	CY 2015	TBD	CY 2016
Clinical Quality: Diabetes	Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	NCQA/ HEDIS			≥ 45.0%	CY 2014	≥ 46.3%	CY 2015	TBD	CY 2016
Clinical Quality: Diabetes	PQI 16: Lower-Extremity Amputation, Patients w/ Diabetes	AHRQ			Not Applicable	Not Applic-able	Reporting Only for SFY 2016	CY 2015	TBD	CY 2016
Clinical Quality: Cardio-vascular Disease	Controlling High Blood Pressure	NCQA/ HEDIS			**≥ 50.0%***	CY 2014	**≥48.6%***	CY 2015	**TBD***	CY 2016
Clinical Quality: Cardio-vascular Disease	Persistence of Beta-Blocker Treatment after a Heart Attack	NCQA/ HEDIS			≥ 73.0%	CY 2014	Eliminated Effective	Eliminated Effective	Eliminated Effective	Eliminated Effective

							SFY 2016	SFY 2016	SFY 2016	SFY 2016
Clinical Quality: Cardio-vascular Disease	PQI 13: Angina without Procedure Admission Rate	AHRQ			Not Applicable	Not Applic-able	Reporting Only for SFY 2016	CY 2015	TBD	CY 2016
Clinical Quality: Cardio-vascular Disease	PQI 8: Heart Failure Admission Rate	AHRQ			Not Applicable	Not Applic-able	Reporting Only for SFY 2016	CY 2015	TBD	CY 2016
Quality Strategy Priority: Support Person and Family Centered Care *Goal: Integrate patient/family feedback on preferences, desired outcomes, and experiences into all care settings and delivery*										
Quality Strategy Focus Area	**Measure**	**Measure-ment Set**			**SFY 2015 Minimum Perf. Std.**	**SFY 2015 Measure-ment Year**	**SFY 2016 Minimum Perf. Std.**	**SFY 2016 Measure-ment Year**	**SFY 2017 Minimum Perf. Std.**	**SFY 2017 Measure-ment Year**
Consumer Satisfaction Survey	Adult Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS			≥ 2.32	CY 2014 (Survey conducted in CY 2015)	≥2.32	CY 2015 (Survey conducted in CY 2016)	TBD	CY 2016 (Survey conducted in CY 2017)
						CY 2014 (Survey				

Consumer Satisfaction Survey	General Child Rating of Health Plan (CAHPS Health Plan Survey)	NCQA/ HEDIS/ CAHPS			≥ 2.51	conducted in CY 2015)	≥2.51	CY 2015 (Survey conducted in CY 2016)	TBD	CY 2016 (Survey conducted in CY 2017)

*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 Section 1. of 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' in the Minimum Performance Standard column for SFY 2015 and SFY 2016, as applicable.
TBD = To be determined

2. INFORMATIONAL ONLY QUALITY MEASURES

The clinical quality measures listed in Table 2. below are informational only. Although no Minimum Performance Standards have been established for these measures, performance results will be used as one component in assessing the quality of care provided by MCPs to the managed care population.

MCPs are evaluated on each measure using statewide results that include all regions in which the MCP has membership. Results for each measure are calculated per MCP and include all of the MCP's Ohio Medicaid members who meet the criteria specified by the methodology for the given measure. MCP performance is assessed using MCP self-reported, audited HEDIS data for the NCQA HEDIS measures listed in Table 2. below. The HEDIS measures in Table 2. are calculated in accordance with *NCQA's Volume 2: Technical Specifications*. The previous calendar year is the standard measurement year for HEDIS data.

2.a. Informational Only Quality Measures, Measurement Sets, and Measurement Years

The informational only quality measures and measurement years for the SFY 2015, SFY 2016, and SFY 2017 contract periods are listed in Table 2. below. The measurement set associated with each measure is also provided.

Table 2. SFY 2015, SFY 2016, and SFY 2017 Informational Only Quality Measures, Measurements Sets, and Measurement Years

Informational Only Quality Measure	Measurement Set	SFY 2015 Measurement Year	SFY 2016 Measurement Year	SFY 2017 Measurement Year
Quality Strategy Priority: Promote Evidence Based Prevention and Treatment Practices ***Goal: Improve the health of priority populations***				
Annual Dental Visits (Total Rate)	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016

Childhood Immunization Status (Combo 2)	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Childhood Immunization Status (Combo 3)	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Childhood Immunization Status (Combo 10)	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Immunizations for Adolescents (Combo 1)	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Breast Cancer Screening	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Cervical Cancer Screening	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Chlamydia Screening in Women (Combined Rate)	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Human Papillomavirus Vaccine for Female Adolescents	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Mental Health Utilization	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Pharmacotherapy Management of COPD Exacerbation: Dispensed a Systemic Corticosteroid within 14 Days of the Event	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016
Pharmacotherapy Management of COPD Exacerbation: Dispensed a Systemic Bronchodilator within 30 Days of the Event	NCQA/ HEDIS	CY 2014	CY 2015	CY 2016

Medication Management for People With Asthma – Medication Compliance 75 Percent, Total Rate	NCQA/ HEDIS	CY 2014	CY 2015	Not Applicable*

*****Effective SFY 2017, this measure is used for compliance assessment, and the measure and associated standard are listed in Table 1. of this appendix.

3. NOTES

3.a. Measures and Measurement Years

ODM reserves the right to revise the measures and measurement years established in this Appendix (and any corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's performance level for that contract period.

3.b. HEDIS Measure Rotation

MCPs may not report rotated measure results, per NCQA methodology, for any HEDIS measure and measurement year listed in Table 1. and Table 2. of this Appendix.

3.c. Performance Standards – Compliance Determination

In the event an MCP's performance cannot be evaluated for a performance measure and measurement year established in Table 1. of this appendix, ODM in its sole discretion will deem the MCP to have met or to have not met the standard(s) for that particular measure and measurement year depending on the circumstances involved (e.g., if a HEDIS measure was assigned an audit result of "Not Report" on the MCP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCP, ODM would deem the MCP to have not met the standard(s) for that measure and measurement year).

3.d. Performance Standards – Retrospective Adjustment

ODM will implement the use of a uniform methodology, as needed, for the retrospective adjustment of any Minimum Performance Standard listed in Table 1. of this Appendix, except for the CAHPS measure standards. This methodology will be implemented at ODM's sole discretion when all three of the following criteria are met.

• The methodology for the standard's associated measure is revised. Note, for HEDIS measures, ODM will not adjust performance measure standards retrospectively due to procedural changes such as revisions to medical record hybrid review timelines.

• For the year the methodology is revised, the performance results for all Ohio Medicaid MCPs all increase or all decrease when compared to the standard setting year (e.g., for the SFY 2013 provider agreement, the standard setting year is HEDIS 2011). Note, this excludes MCPs without results for both years.

• For the year the methodology is revised, the performance results for three or more Ohio Medicaid MCPs each change by at least three percentage points (e.g., increase from 56.0% to 59.0%) when compared to the standard setting year.

For a comprehensive description of the standard adjustment methodology, see *ODM Methods for the Retrospective Adjustment of Quality and P4P Measure Standards.*

APPENDIX N

COMPLIANCE ASSESSMENT SYSTEM

I. General Provisions of the Compliance Assessment System

A. The Compliance Assessment System (CAS) sets forth sanctions that may be assessed by the Ohio Department of Medicaid (ODM) against the Managed Care Plan (MCP) if the MCP is found to have violated this Provider Agreement, or any other applicable law, rule, or regulation. It does not in any way limit ODM from requiring Corrective Action Plans (CAPs) and program improvements, or from imposing any of the sanctions specified in OAC rule 5160-26-10 or any other additional compliance actions, including the proposed termination, amendment, or nonrenewal of this Provider Agreement. Any actions undertaken by ODM under this Appendix are not exclusive to any other compliance action it may impose or that is available to ODM under applicable law or regulations.

B. As stipulated in OAC rule 5160-26-10, regardless of whether ODM imposes a sanction, the MCP is required to initiate corrective action for any MCP program violation or deficiency as soon as the violation or deficiency is identified by the MCP or ODM. The MCP is required to report to ODM when it becomes aware of any violation that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the MCP to deliver covered services, or affect the member's ability to access covered services.

C. 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 this 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.

D. Program violations that reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODM first becomes aware of this noncompliance.

E. ODM retains the right to use its discretion to determine and apply the most appropriate sanction based on the severity of the noncompliance, a pattern of repeated noncompliance, and number of beneficiaries affected.

F. ODM will issue all notices of noncompliance in writing to the identified MCP contact.

II. Types of Sanctions/Remedial Actions

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

A. Corrective Action Plans (CAPs)

A CAP is a structured activity, process 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 MCP to ensure its compliance with a program requirement remain in effect for twenty-four months 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 twelve months from the date of implementation.

Where ODM has determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a CAP, ODM may require the MCP to comply with an ODM-developed or "directed" CAP.

Where a sanction is assessed for a violation in which an MCP has previously been assessed a CAP the MCP may be assessed escalating sanctions under this Provider Agreement.

B. Financial Sanctions

B.1. Financial Sanctions Assessed Due to Accumulated Points

On the effective date of this Agreement, MCP shall carry over all active points from the SFY 2014 Provider Agreement. Points will accumulate over a rolling 12-month schedule. Points more than 12 months old will expire.

No points will be assigned for a violation if an MCP is able to document that the precipitating circumstances were completely beyond its control and could not have been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.).

In cases where an MCP-contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), ODM may assess points unless to the satisfaction of ODM: (1) the MCP can document that it provided sufficient notification or education to providers of applicable program requirements and prohibited activities; and (2) the MCP took immediate and appropriate action to correct the problem and to ensure that it will not reoccur. ODM will review repeated incidents and determine whether the MCP has a systemic problem. If ODM determines that a systemic problem exists, further sanctions or remedial actions may be assessed against the MCP.

B.1.1. 5 Points

ODM may in its discretion assess five (5) points when the MCP fails to meet an administrative or procedural program requirement that (1) impairs a member's or potential enrollee's ability to obtain accurate information regarding MCP services, (2) violates a care

management process, (3) impairs a member's or potential enrollee's ability to obtain correct information regarding services or (4) infringes on the rights of a member or potential enrollee. Examples of five (5) point violations include, but are not limited to the following:

- Failure to provide accurate provider panel information.
- Failure to provide member materials to new members in a timely manner.
- Failure to comply with appeal, grievance**,** or state hearing requirements, including the failure to notify a member of his or her right to a state hearing when the MCP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to staff a 24-hour call-in system with appropriate trained medical personnel.
- Failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Provision of false, inaccurate or materially misleading information to ODM, health care providers, the MCP's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify ODM, or members, of provider panel terminations.
- Failure to update website provider directories as required.
- Failure to comply with a CAP.
- Failure to actively participate in quality improvement projects or performance improvement projects facilitated by ODM and/or the EQRO.
- Failure to meet provider network performance standards.
- A violation of a care management process specified in Appendix K of the Provider Agreement that does not meet the standards for a 10 point violation. Examples include but are not limited to the following:
    - Failure to ensure that staff performing care management functions are operating within their professional scope of practice, are appropriately responding to a member's care management needs, or are complying with the state's licensure/credentialing requirements;
    - Failure to adequately assess an individual's needs including the evaluation of mandatory assessment domains;
    - Failure to update an assessment upon a change in health status, needs or significant health care event;
    - Failure to develop or update a care plan that appropriately addresses assessed needs of a member;
    - Failure to monitor the care plan;
    - Failure to complete a care gap analysis that identifies gaps between recommended care and care that is received by a member;
    - Failure to update the care plan in a timely manner when gaps in care or change in need are identified;
    - Failure to coordinate care for a member across providers, specialists, and team members, as appropriate;
    - Failure to adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls; or

- Failure to make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; conduct timely follow up with the member and provider, as appropriate; or arrange for services specified in the discharge/transition plan.

B.1.2. 10 Points

ODM may assess ten (10) points when the MCP fails to meet a program requirement that could, as determined by ODM: (1) affect the ability of the MCP to deliver, or a member to access, covered services; (2) place a member at risk for a negative health outcome; or (3) jeopardize the safety and welfare of a member. Examples include, but are not limited to, the following:

- Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).
- Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member.
- Failure to provide medically-necessary Medicaid covered services to members.
- Failure to participate in transition of care activities or discharge planning activities.
- Failure to process prior authorization requests within the prescribed time frames.
- Repeated failure to comply with a CAP.
- The imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program.
- Misrepresentation or falsification of information that the MCP furnishes to ODM.
- Misrepresentation or falsification of information that the MCP furnishes to a member, potential member, or health care provider.
- Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210.
- Violation of a care management process as specified in Appendix K.

B.1.3. Progressive Sanctions Based on Accumulated Points

Progressive sanctions will be based on the number of points accumulated at the time of the most recent incident. A CAP or other sanction may be imposed in addition to the fines listed below. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	CAP + No fine
16-25 Points	CAP + $5,000 fine
26-50 Points	CAP + $10,000 fine
51-70 Points	CAP + $20,000 fine

71-100 Points	CAP + $30,000 fine
100+ Points	Proposed Provider Agreement Termination

B.2 Specific Pre-Determined Sanctions

B.2.1. Adequate network-minimum provider panel requirements

Any deficiencies in the MCP's provider network specified in Appendix H of this Provider Agreement or by ODM, may result in the assessment of a $1,000 nonrefundable fine for each category (practitioners, PCP capacity, hospitals), for each county. Compliance will be assessed at least quarterly.

ODM may assess additional sanctions (e.g. CAPs, points, fines) if (1) an MCP violates any other provider panel requirements or (2) an MCP's member has experienced problems accessing necessary services due to lack of an adequate provider panel.

B.2.2. Late Submissions

All submissions, data and documentation submitted by an MCP must be received by ODM within the specified deadline and must represent the MCP in an honest and forthright manner. If the MCP fails to provide ODM with any required submission, data or documentation, ODM may assess a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODM. Assessments for late submissions will be done monthly.

If an MCP is unable to meet a program deadline or data/documentation submission deadline, the MCP must submit a written request to its Contract Administrator for an extension of the deadline, as soon as possible, but no later than 3 PM, EST, on the date of the deadline in question. Requests for extensions should only be submitted where unforeseeable circumstances have made it impossible for the MCP to meet a deadline stipulated by ODM. All such requests will be evaluated upon this standard. ODM may assess compliance against an MCP for late submission unless ODM has granted written approval for a deadline extension request.

B.2.3. Noncompliance with Claims Adjudication Requirements

If ODM finds that an MCP is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, ODM may assess the MCP with a monetary sanction of $20,000 per day for the period of noncompliance. Additionally, the MCP may be assessed 5 points per incident of noncompliance.

If ODM has identified specific instances where an MCP has failed to take the necessary steps to comply with the requirements specified in Appendix C of the Agreement by (1) failing to notify non-contracting providers of procedures for claims submissions when requested or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the MCP may be assessed 5 points per incident of noncompliance.

B.2.4. Noncompliance with Financial Performance Measures or the Submission of Financial Statements

If an MCP fails to meet any standard for 2.a., 2.b., 2.c., or 2.d of Appendix J, ODM may require the MCP to complete a CAP and specify the date by which compliance must be demonstrated. Failure by the MCP to meet the standard or otherwise comply with the CAP by the specified date may result in a new enrollment freeze unless ODM determines that the deficiency does not potentially jeopardize access to or quality of care or affect the MCP's ability to meet administrative requirements (e.g., prompt pay requirements). Justifiable reasons for noncompliance may include one-time events (e.g., MCP investment in information system products).

If Financial Statements are not submitted to the Ohio Department of Insurance (ODI) by the due date, the MCP continues to be obligated to submit the report to ODM by ODI's originally specified due date unless the MCP requests and is granted an extension by ODM.

If an MCP fails to submit complete quarterly and annual Financial Statements on a timely basis, ODM will deem this a failure to meet the standards and may impose the noncompliance sanctions listed above for indicators 2.a., 2.b., 2.c., and 2.d, including a new enrollment freeze. The new enrollment freeze will take effect at the first of the month following the month in ODM has determined that the MCP was non-compliant for failing to submit financial reports timely.

B.2.5. Noncompliance with Medical Loss Ratio (MLR) Requirements for the Adult Extension Population

B.2.5.1. Establishment of MLR

For Adult Extension members, ODM shall perform an MLR calculation as defined in the ODM Methods for Financial Performance Measures for the periods stated below.

a. ODM shall perform MLR calculations for the incurred periods of January 1, 2014 through December 31, 2014, ("first period"), and January 1, 2015 through December 31, 2015, ("second period").
b. For each period, ODM or its designee will initiate the MLR calculation 12 months after the end of each period.
c. ODM will give consideration to paid claims data through December 31, 2015, for services incurred during the first period, and through December 31, 2016, for the second period. In the determination of Incurred Medical Claims, no estimate of claims to be paid more than 12 months beyond the end of the period will be considered. Incurred Medical Claims includes an adjustment for pharmaceutical rebates collected by the MCP.
d. The MCP shall provide and certify any data used in the calculation of the MLR in accordance with 42 CFR 438.600 et al. Data submitted to ODM is subject to review or audit by ODM or its designee.

e. Net Capitation Payments equals Earned Premiums minus Federal, State, and Local Taxes and Licensing or Regulatory Fees.
f. Allowed Medical Expense equals Incurred Medical Claims plus Expenses for Activities That Improve Health Care Quality (as defined in 45 CFR 158.150)

B.2.5.2. MLR Rebate

The MCP shall be required to expend at minimum 85 percent of Net Capitation Payments for the Extension population on Allowed Medical Expenses. If the MCP does not meet the minimum 85 percent MLR threshold, then the MCP shall return to the State the difference between 85 percent of total Net Capitation Payments to the MCP and actual Allowed Medical Expenses incurred. After completion of the MLR calculation, if it is determined that the MLR of the MCP is less than 85 percent, then ODM will notify the MCP of the capitation payments to be returned to the State.

a. The MCP shall remit to the State the full amount due no later than ninety (90) calendar days after the date ODM delivers notice to the MCP of that amount.
b. It is explicitly noted that this MLR contract provision may result in payment by the MCP to ODM.
c. In the event of a change in capitation rate for the Extension population, for each period provided in this Provision, a MLR calculation in accordance with the requirements of this Provision shall be re-determined by ODM. Subsequent to this re-determination, adjustments to payments in accordance with this Provision may result in changes in payment by the MCP to ODM.

B.2.6. Noncompliance with Reinsurance Requirements

If ODM determines that (1) an MCP has failed to maintain reinsurance coverage as specified in Appendix J, (2) an MCP's deductible exceeds $100,000 without approval from ODM, or (3) an MCP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODM, then ODM may require the MCP to pay a monetary sanction to ODM. The amount of the sanction will be the lesser of (1) 10% of the difference between the estimated amount of what the MCP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCP actually paid while it was out of compliance or (2) $50,000.

If ODM determines that an MCP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, ODM may subject the MCP to a CAP.

B.2.7. Noncompliance with Prompt Payment

ODM may impose progressive sanctions on an MCP that does not comply with the prompt pay requirements as specified in Appendix J of this Agreement. The first violation during a rolling 12-month period may result in the submission of quarterly prompt pay and monthly status reports to ODM until the next quarterly report is due. The second violation during a rolling 12-month period may result in a requirement to submit monthly status reports and a refundable fine equal to 5% of the MCP's monthly premium payment or $300,000, whichever is less. ODM may apply the refundable fine in lieu of a nonrefundable fine and refund the money only after the MCP complies with the required standards for two (2) consecutive quarters. Subsequent violations may result in an enrollment freeze.

If ODM finds that an MCP has not complied with the prompt pay requirements for any time period for which a report and signed attestation have been submitted representing the MCP as being in compliance, ODM may subject the MCP to an enrollment freeze of not less than three (3) months duration.

B.2.8. Noncompliance with Clinical Laboratory Improvement Amendments (CLIA)

If an MCP fails to comply with CLIA requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of a $1,000 for each documented violation.

B.2.9. Noncompliance with Abortion and Sterilization Hysterectomy Requirements

If an MCP fails to comply with abortion and sterilization requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of $2,000 for each documented violation. Additionally, MCPs must take all appropriate action to correct each violation documented by ODM.

B.2.10. Refusal to Comply with Program Requirements

If ODM has instructed an MCP that it must comply with a specific program requirement and the MCP refuses, such refusal constitutes documentation that the MCP is no longer operating in the best interests of the MCP's members or the state of Ohio, and ODM may move to terminate or non-renew this Provider Agreement.

B.2.11. Data Quality Submission Requirements and Measures (as specified in Appendix L)

B.2.11.1. Data Quality Submission Requirements

B.2.11.1.1. Annual Submission of MCP Self-Reported, Audited HEDIS Data

Performance is monitored annually. If an MCP fails to submit its self-reported, audited HEDIS data to ODM as specified in Appendix L, the MCP will be considered non-compliant with the standards for the self-reported, audited HEDIS performance measures in Appendix M for the corresponding contract period per section B.2.12. of this Appendix. In addition, the MCP may be disqualified from participation in the P4P incentive system in Appendix O for the corresponding contract period.

B.2.11.1.2. Annual Submission of Final HEDIS Audit Report (FAR)

Performance is monitored annually. If an MCP fails to submit it's FAR to ODM as specified in Appendix L, the MCP will be considered non-compliant with the standards for the self-reported, audited HEDIS performance measures in Appendix M for the corresponding contract period per section B.2.12. of this Appendix. In addition, the MCP may be disqualified from participation in the P4P incentive system in Appendix O for the corresponding contract period.

ODM will review each MCP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. An MCP may be required to submit to ODM requested documentation to account for an NR audit designation. Based on its review of an MCP's FAR and any NR audit designations assigned, ODM reserves the right to pursue corrective action (such as requiring the MCP to implement a corrective action plan to resolve data collection and/or reporting issues).

B.2.11.1.3. Data Certification Requirements for HEDIS IDSS Data and HEDIS Audit Report

Performance is monitored annually. If an MCP fails to submit a required data certification letter to ODM within the required time frame, ODM may impose a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODM.

B.2.11.1.4. Annual CAHPS Survey Administration and Data Submission

Performance is monitored annually. If an MCP fails to administer a CAHPS survey and submit the survey data to NCQA, the CAHPS Database, and ODM's designee, as specified in Appendix L, ODM may impose a non-refundable $300,000 monetary sanction. In addition, the MCP will be considered non-compliant with the standards for the CAHPS performance measure in Appendix M for the corresponding contract period, per section B.2.12. of this Appendix.

B.2.11.1.5. CAHPS Data Certification Requirements

Performance is monitored annually. If an MCP fails to submit a required CAHPS data certification letter to ODM within the required time frame, ODM may impose a nonrefundable fine of $100 per day, unless the MCP requests and is granted an extension by ODM.

B.2.11.2. Data Quality Measures

The MCP must submit to ODM, by the specified deadline and according to ODM's specifications, all required data files and requested documentation needed to calculate each measure listed under subsections of B.2.11.2. If an MCP fails to comply with this requirement for any measure listed under B.2.11.2 then the MCP will be considered noncompliant with the standard(s) for that measure.

ODM reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

The monetary sanction for each measure listed under B.2.11.2 shall not exceed $300,000 during each evaluation period.

Unless otherwise specified, sanctions for noncompliance are assessed per MCP and measure for the MCP's overall Ohio Medicaid population (i.e., ABD and CFC and Adult Extension members).

B.2.11.2.1. Encounter Data Volume

Performance is monitored once every quarter for the entire measurement period for each of the following populations: ABD adults, ABD children, CFC members, and Adult Extension members. Sanctions for non-compliance will be assessed separately, by population. For each population, if the standard is not met for every service category in all quarters of the measurement period, the MCP will be determined to be noncompliant for the measurement period.

ODM will issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM will issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM will issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM will impose a monetary sanction of two percent of the current month's premium and delivery payments. (Monetary sanctions will not be levied in subsequent, consecutive quarters that an MCP is determined to be noncompliant.) If an MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM will impose a new member enrollment freeze. Once the MCP is determined to be compliant with the standard and the violations or deficiencies are resolved to the satisfaction of ODM, any applicable sanctions will be lifted (e.g., enrollment freeze), and any applicable monetary sanctions will be returned.

B.2.11.2.2. Rejected Encounters

Performance is monitored once every quarter for Measure 1 and once every month for Measure 2. Compliance determination with the standard applies only to the measurement period under consideration and does not include performance in previous measurement periods. Files in the ODM-specified medium per format that are totally rejected will not be considered in the determination of noncompliance. If the standard is not met for every file type, the MCP may be determined to be noncompliant for the measurement period.

Effective SFY 2016, ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may issue a

CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the current month's premium and delivery payments. If an MCP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Once the MCP is determined to be compliant with the standard and the violations or deficiencies are resolved to the satisfaction of ODM, any applicable sanctions will be lifted (e.g., enrollment freeze) and any applicable monetary sanctions will be returned. Special consideration may be made for MCPs with less than 1,000 members.

B.2.11.2.3. Acceptance Rate

Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months. If the standard is not met for every file type, the MCP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the current month's premium and delivery payments. If an MCP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Once the MCP is determined to be compliant with the standard, and the violations or deficiencies are resolved to the satisfaction of ODM, any applicable sanctions may be lifted (e.g., enrollment freeze) and any applicable monetary sanctions may be returned. Special consideration may be made for MCPs with less than 1,000 members.

B.2.11.2.4. Encounter Data Accuracy Study - Payment Accuracy Measure

The first time an MCP is determined to be noncompliant with the standard for either level 1 or level 2 for this measure, the MCP must implement a CAP which identifies interventions and a timeline for resolving data quality issues related to payments. Additional reports to ODM addressing targeted areas of deficiencies and progress implementing data quality improvement activities may be required. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard for either level 1 or level 2 for this measure, ODM may impose a monetary sanction of one percent of the current month's premium and delivery payments. Once the MCP is determined to be compliant with the standard for level 1 and level 2 for this measure and the violations or deficiencies are resolved to the satisfaction of ODM, any applicable monetary sanctions will be returned.

B.2.11.2.5. Encounter Data Accuracy Study - Delivery Payment Measure – Compliance with this measure will only be assessed for the CFC population and Adult

Extension members (combined). The MCP must participate in a detailed review of delivery payments made for deliveries during the measurement period. The required accuracy rate for encounters generating delivery payments is 100%; therefore, any duplicate delivery payments or delivery payments that are not validated must be returned to ODM. For all encounter data accuracy studies that are completed during this contract period, if an MCP does not meet the minimum record submittal rate of 85%, ODM may impose a non-refundable $10,000 monetary sanction. However, no monetary sanctions will be imposed if the MCP is in its first contract year of Medicaid program participation.

B.2.11.2.6. Encounter Data Payments Compared to Managed Care Cost Report Information

Performance is monitored once every quarter for the entire measurement period for each of the following populations: ABD, CFC, and Adult Extension. Sanctions for non-compliance will be assessed separately, by population. For each population, if the standard is not met for every service category in all quarters of the measurement period, the MCP will be determined to be noncompliant for the measurement period.

Effective SFY 2017, ODM will issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM will issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM will issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM will impose a monetary sanction of two percent of the current month's premium and delivery payments. (Monetary sanctions will not be levied in subsequent, consecutive quarters that an MCP is determined to be noncompliant.) If an MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM will impose a new member enrollment freeze. Once the MCP is determined to be compliant with the standard and the violations or deficiencies are resolved to the satisfaction of ODM, any applicable sanctions will be lifted (e.g., enrollment freeze), and any applicable monetary sanctions will be returned.

<u>B.2.11.2.7. Incomplete Rendering Provider Data</u>
Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCP will be noncompliant for the measurement period.

Effective SFY 2016, ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the current month's premium and delivery payments. If an MCP is determined to be

noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze. Once the MCP is determined to be compliant with the standard and the violations or deficiencies are resolved to the satisfaction of ODM, any applicable sanctions will be lifted (i.e., enrollment freeze), and any applicable monetary sanctions will be returned.

B.2.11.2.8. NPI Provider Number Usage without Medicaid/Reporting Provider Numbers
Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCP may be determined to be noncompliant for the measurement period.

Effective SFY 2016, ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the current month's premium and delivery payments. If an MCP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze. Once the MCP is determined to be compliant with the standard and the violations or deficiencies are resolved to the satisfaction of ODM, any applicable sanctions will be lifted (i.e., enrollment freeze), and any applicable monetary sanctions will be returned.

B.2.11.2.9. Encounter Submissions per *ODM Encounter Data Submission Schedule*
Performance is monitored once every month. If the standard is not met for the measurement period, the MCP will be noncompliant for the measurement period.

Effective January 2015, ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may impose a monetary sanction of one percent of the current month's premium and delivery payments. If an MCP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a monetary sanction of two percent of the current month's premium and delivery payments. Once the MCP is determined to be compliant with the standard and the violations or deficiencies are resolved to the satisfaction of ODM, any applicable monetary sanctions will be returned.

B.2.11.2.10. Timeliness of Encounter Data Submission – Performance is monitored once every month. If the standard is not met for the measurement period, the MCP will be noncompliant for the measurement period.

Effective July 2016, ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time an MCP is determined to be noncompliant with the standard for this measure, ODM may impose a monetary sanction of one percent of the current month's premium and delivery payments. If an MCP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a monetary sanction of two percent of the current month's premium and delivery payments. Once the MCP is determined to be compliant with the standard and the violations or deficiencies are resolved to the satisfaction of ODM, any applicable monetary sanctions will be returned.

B.2.12. Performance Evaluation Measures (as specified in Appendix M)
The MCP must submit to ODM, by the specified deadline and according to ODM's specifications, all required data files and requested documentation needed to assess each performance evaluation measure specified in Appendix M. If an MCP fails to comply with this requirement for any performance measure listed in Appendix M, the MCP will be considered noncompliant with the standard(s) for that measure.

ODM reserves the right to withhold an assessment of noncompliance under this Section due to unforeseeable circumstances.

For each measure in Appendix M, one or more rates are calculated. Each rate has an associated Minimum Performance Standard. When an MCP fails to meet a Minimum Performance Standard listed in Appendix M, for a measure for which noncompliance sanctions are applicable, the MCP may be assessed a sanction for noncompliance with the standard. ODM has established uniform noncompliance sanctions for these standards.

A series of progressive sanctions may be issued for consecutive instances of noncompliance with the standard established for a given rate. For example, four rates, corresponding to the HEDIS age breakouts, are calculated for the *Children and Adolescents' Access to Primary Care Practitioners* measure. An MCP failing to meet the standard established for the '12-24 Months' rate in three consecutive measurement periods would be subject to progressive sanctions. However, an MCP failing to meet the standard established for the '7-11 Years' rate in one measurement period and the '12-19 Years' rate in the next would not be subject to progressive sanctions, as these only apply to the standard established for the same rate.

For the standard established for each rate listed in Appendix M, for measures for which noncompliance sanctions are applicable, an MCP may be assessed sanctions for instances of noncompliance as follows:

- **1st instance, or subsequent but nonconsecutive instance, of noncompliance** – ODM may impose a monetary sanction in the amount of one quarter of one percent of the current month's premium and delivery payments. Once the MCP is determined to be in compliance with the standard and the violations/deficiencies are resolved to the satisfaction of ODM, the monetary sanction will be returned.

- **2nd consecutive instance of noncompliance** – ODM may impose a monetary sanction in the amount of one quarter of one percent of the current month's premium and delivery payments. This is non-refundable.
- **3rd consecutive instance of noncompliance** – ODM may impose a monetary sanction in the amount of one half of one percent of the current month's premium and delivery payments. This is non-refundable.

Additionally, if ODM determines that an MCP is noncompliant with greater than 50% of the performance evaluation standards listed in Appendix M, for which noncompliance sanctions are applicable, for two consecutive contract years, ODM will have the option to terminate the MCP's Provider Agreement.

B.2.13. Intentionally omitted.

B.2.14. Administrative Compliance Assessment (as specified in Appendix K)
Compliance with administrative standards is performed by the external quality review organization, as specified by ODM. For each documented instance of noncompliance with an administrative standard, the MCP may be required to submit a corrective action plan as specified by ODM to remedy the identified deficiency.

B.2.15. Care Management Program Evaluation Measures (as specified in Appendix K)
For the standard established for each measure listed in Appendix K.2.h.ii.b.6., an MCP may be assessed sanctions for instances of noncompliance as follows:

- **1st instance, or subsequent but nonconsecutive instance, of noncompliance –** ODM may impose a monetary sanction in the amount of one quarter of one percent of the current month's premium and delivery payments. Once the MCP is determined to be in compliance with the standard and the violations or deficiencies are resolved to the satisfaction of ODM, the monetary sanction will be returned.
- **2nd consecutive instance of noncompliance** – ODM may impose a monetary sanction in the amount of one quarter of one percent of the current month's premium and delivery payments. This is non-refundable.
- **3rd consecutive instance of noncompliance** – ODM may impose a monetary sanction in the amount of one half of one percent of the current month's premium and delivery payments. This is non-refundable.
- **4th consecutive instance of noncompliance** – ODM may terminate the MCP's Provider Agreement.

B.2.16. High Risk Care Management Staffing Ratio
ODM may assess sanctions on the MCP for instances of non-compliance with the high risk care management staffing ratio minimum performance standard specified in K.2.ii.h.b.4 as follows:

- 1st instance, or subsequent but nonconsecutive instance, of non-compliance – ODM may impose a monetary sanction in the amount of one quarter of one percent of the current month's premium and delivery payments. Once the MCP is compliant with the standard and resolved to satisfaction of ODM, the monetary sanction will be refunded.

- 2nd consecutive instance of noncompliance – ODM may impose a monetary sanction in the amount of one quarter of one percent of the current month's premium and delivery payments. This amount is non-refundable.

- 3rd consecutive instance of noncompliance – ODM may impose a monetary sanction in the amount of one half of one percent of the current month's premium and delivery payments. This amount is non-refundable.

- 4th consecutive instance of noncompliance – ODM may terminate the MCP provider agreement.

B.2.17. Maintenance of National Committee for Quality Assurance Health Plan Accreditation
For the standard established in Appendix C, ODM may assess the following sanctions for non-compliance as follows:

If the MCP receives a Provisional accreditation status - the MCP will be required to complete a resurvey within 12 months of the accreditation decision. If the resurvey results in a Provisional or Denied status, ODM will consider this a material breach of the provider agreement and may terminate the provider agreement with the managed care plan.

If the MCP receives a Denied accreditation status - then ODM considers this a material breach of the provider agreement and may terminate the provider agreement with the MCP.

B.2.18. Noncompliance with Provision of Transportation Services
If an MCP fails to comply with the transportation requirements specified in Appendix C.19.a. of this Provider Agreement, when providing Medicaid-covered transportation services and when members must travel more than 30 miles to receive services, ODM may impose a nonrefundable fine in the amount of $1,000 for each violation. ODM may assess additional sanctions (e.g., CAPs, points, fines) as provided for in Appendix N.II.

B.3. Fines
Refundable or nonrefundable fines may be assessed separately or in combination with other sanctions or remedial actions. The total fines assessed in any one month will not exceed 15% of one month's payment from ODM to the MCP. Unless otherwise stated, all fines are nonrefundable.

B.3.1 Refundable and nonrefundable monetary sanctions/assurances must be paid by the MCP to ODM within thirty (30) calendar days of invoice date by the MCP, or as otherwise directed by ODM in writing. In addition, per ORC Section 131.02, payments

owed to the State not received within forty-five (45) calendar days will be certified to the Attorney General's (AG's) office. The AG's Office will assess the appropriate collection fee for MCP payments certified to the AG's Office.

B.3.2. Monetary sanctions imposed by ODM will be based on the most recent premium and delivery payments in the month of the cited deficiency.

B.3.3. Any monies collected through the imposition of a refundable fine will be returned to the MCP (minus any applicable collection fees owed to the AG's Office if the MCP has been delinquent in submitting payment) after it has demonstrated full compliance with the particular program requirement, as determined by ODM.

B.3.4. An MCP is required to submit a written request for refund to ODM at the time it believes is appropriate before a refund of monies will be considered.

B.4. New Enrollment Freezes

Notwithstanding any other sanction or point assessment that ODM may impose on the MCP under this Provider Agreement, ODM may prohibit an MCP from receiving new enrollment through consumer initiated selection or the assignment process if any of the following occur: (1) the MCP has accumulated a total of 51 or more points during a rolling 12-month period; (2) the MCP has failed to fully implement a plan of correction within the designated time frame; (3) circumstances exist that potentially jeopardize the MCP's members' access to care, as solely determined by ODM; or (4) the MCP is found to have a pattern of repeated or ongoing noncompliance, as solely determined by ODM. Examples of circumstances that ODM may consider as jeopardizing member access to care include, but are not limited to, the following:

- The MCP has been found by ODM to be noncompliant with the prompt payment or the non-contracting provider payment requirements;
- The MCP has been found by ODM to be noncompliant with the provider panel requirements specified in Appendix H of the Provider Agreement;
- The MCP has refused to comply with a program requirement after ODM has directed the MCP to comply with the specific program requirement;
- The MCP has received notice of proposed or implemented adverse action by the ODI; or
- The MCP has failed to provide adequate provider or administrative capacity.

Payments provided for under the Provider Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.730.

B.5. Reduction of Assignments

ODM has discretion over how member auto-assignments are made. ODM may reduce the number of assignments an MCP receives to ensure program stability within a region, or upon a determination that the MCP lacks sufficient capacity to meet the needs of the increased enrollment

volume. ODM may determine that an MCP has demonstrated a lack of sufficient capacity under circumstances that include, but are not limited to the following:

- The MCP has failed to maintain an adequate provider network;
- The MCP has failed to provide new member materials by the member's effective date;
- The MCP has failed to meet the minimum call center requirements;
- The MCP has failed to meet the minimum performance standards for members with special health care needs; or
- The MCP has failed to provide complete and accurate data files regarding appeals or grievances, or its Care Management System (CAMS) files.

B.6. Death or Injury to Member

ODM may immediately terminate or suspend this Agreement if an MCP's failure to perform, or properly perform, any of the requirements in this Agreement results in the death of or serious injury to, an MCP's member, as determined by ODM.

III. Request for Reconsiderations

An MCP may seek reconsideration of any sanction or remedial action imposed by ODM including points, fines, and member enrollment freezes. An MCP may not seek reconsideration of an action by ODM that results in changes to the auto-assignment of members and the imposition of directed CAPs. The MCP must submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:

A. An MCP will have ten (10) business days to request reconsideration after receiving a notice of a sanction to be imposed by ODM. If ODM imposes an enrollment freeze based on access to care concerns, the enrollment freeze will be imposed concurrent with initiating notification to the MCP. The MCP should include with its request for reconsideration any information that it would like to have reviewed in the reconsideration, unless ODM extends the time frame in writing.

B. An MCP must submit a request for reconsideration either by email to the designated Contract Administrator (CA), or by overnight mail to ODM's Bureau of Managed Care (BMC). The request for reconsideration must be received by ODM no later than the tenth business day after the date that the MCP receives notice of the imposition of the remedial action by ODM.

C. A request for reconsideration must explain in detail why the specified sanction should not be imposed. In considering an MCP's request for reconsideration, ODM will review only the written material submitted by the MCP.

D. ODM will make a final decision, or request additional information, within ten (10) business days after receiving the request for reconsideration.

E. If ODM requests additional information from the MCP, a final reconsideration decision will be made within three (3) business days after the date by which the MCP is required to submit the additional information. If ODM requires additional time in rendering the final reconsideration decision, the MCP will be notified of the need for additional time in writing.

F. If ODM decides a reconsideration request, in whole or in part, in favor of the MCP, both the sanction and the points associated with the incident may be rescinded or reduced, at the discretion of ODM. The MCP may still be required to submit a CAP if ODM, in its discretion, believes that a CAP is still warranted under the circumstances.

APPENDIX O

PAY-FOR-PERFORMANCE (P4P)

The Ohio Department of Medicaid (ODM) has established a Pay for Performance (P4P) Incentive System to provide financial rewards to MCPs that achieve specific levels of performance in program priority areas. The P4P Incentive System is aligned with specific priorities, goals, and areas of clinical focus identified in the ODM Quality Strategy. Standardized clinical quality measures derived from a national measurement set (i.e., HEDIS) are used to determine incentive payments. Performance bonus payments made under the P4P Incentive System are funded through the state's managed care program performance payment fund.

1. P4P INCENTIVE SYSTEM

One P4P Incentive System determination is made annually, per MCP. Results for each P4P measure are calculated per MCP, statewide, and include all regions in which the MCP has membership. MCPs are required to develop and implement improvement initiatives in areas of low performance.

1.a. SFY 2015 P4P

1.a.i. Determination

For SFY 2015, ODM will calculate a 'bonus amount' for each participating MCP that is equal to 1.25% of the net premium and delivery payments made to the MCP between January 1, 2014 and December 31, 2014 pursuant to the applicable Medicaid Managed Care Provider Agreements. Each participating MCP may be awarded a performance bonus payment of up to 100% of the MCP's bonus amount.

Performance will be assessed on six measures to determine the amount of each MCP's performance bonus payment. The measures are equally weighted (i.e., each measure is worth one sixth of the MCP's total bonus amount). For each measure, the MCP will be awarded from 0% up to 100% of one sixth of the bonus amount. Ten P4P performance levels, with corresponding performance standards, are established for each measure, above the Minimum Performance Standard set for the measure in Appendix M, *Quality Measures and Standards*. An MCP's performance result, in comparison to these levels, will determine the percentage to be awarded per measure. MCPs failing to meet the standard for level one will be awarded 0% for the measure. The P4P measures and corresponding standards for the ten performance levels are provided in Table1. below. Each measure's Minimum Performance Standard, as set forth in Appendix M, is provided for comparative purposes only.

Table1. SFY 2015 P4P Measures and Performance Bonus Payment Standards

Quality Strategy Priority: Effective and Efficient Healthcare Administration ***Goal: Sustain a Quality Focused Organization*** **Quality Strategy Focus Area – Pay for Performance (P4P)**							
SFY 2015 P4P Measures and Performance Bonus Payment Standards							
		Standards that Determine % of Bonus Amount Awarded, by Measure					
P4P Perf. Level	**Percent of Bonus Amount Awarded**	Follow-Up After Hospitalization for Mental Illness (7 Days)	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Controlling High Blood Pressure (Patients with Hypertension)	Use of Appropriate Medications for People With Asthma Meds	Appropriate Treatment for Children with Upper Respiratory Infection	Comprehensive Diabetes Care: HbA1c Control (<8.0%)
10	100%	57.7%	90.4%	63.7%	88.2%	90.0%	55.7%
9	87%	55.4%	89.5%	62.4%	87.7%	89.0%	54.3%
8	74%	53.0%	88.7%	61.2%	87.3%	88.1%	52.9%
7	61%	50.7%	87.8%	60.0%	86.8%	87.2%	51.5%
6	50%	48.4%	87.0%	58.7%	86.3%	86.3%	50.1%
5	39%	46.1%	86.1%	57.5%	85.9%	85.3%	48.7%
4	28%	43.3%	85.0%	56.0%	85.2%	84.4%	47.4%
3	19%	40.5%	83.9%	54.5%	84.5%	83.5%	46.1%
2	11%	37.7%	82.8%	53.0%	83.9%	82.5%	44.7%
1	4%	35.0%	81.7%	51.5%	83.2%	81.6%	43.4%
	0%	≤ 34.9%	≤ 81.6%	≤ 51.4%	≤ 83.1%	≤ 81.5%	≤43.3%
MPS		32.2%	80.5%	50.0%	82.5%	80.6%	42.1%

MPS = Minimum Performance Standard (*established in Appendix M, and provided above for reference*)

Note: The measurement year for all six SFY 2015 P4P measures is CY 2014. MCP performance is assessed using MCP self-reported, audited HEDIS data calculated in accordance with *NCQA HEDIS 2015, Volume 2: Technical Specifications.*

1.a.ii. Quality Improvement

The P4P Incentive System measures are aligned with the ODM Quality Strategy and thus 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 MCP quality improvement, ODM will require each MCP to develop and implement one Quality Improvement Project (QIP), as outlined in paragraph 3.a. of Appendix K, for each MCP SFY 2015 P4P measure result that does not meet the corresponding standard listed below. The MCP must adhere to ODM-specified reporting and submission guidelines in completing the QIP.

Follow-Up After Hospitalization for Mental Illness (7 Days)	≥ 21.3%
Prenatal and Postpartum Care: Timeliness of Prenatal Care	≥ 69.2%
Controlling High Blood Pressure (Patients with Hypertension)	≥ 39.6%
Use of Appropriate Medications for People With Asthma Meds	≥ 78.8%
Appropriate Treatment for Children with Upper Respiratory Infection	≥ 76.3%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	≥ 32.6%

1.b. SFY 2016 P4P

1.b.i. Determination

For SFY 2016, ODM will calculate a 'bonus amount' for each participating MCP that is equal to 1.25% of the net premium and delivery payments made to the MCP between January 1, 2015 and December 31, 2015 pursuant to the applicable Medicaid Managed Care Provider Agreements. Each participating MCP may be awarded a performance bonus payment of up to 100% of the MCP's bonus amount.

Performance is assessed on seven measures. The MCP's total bonus amount is divided equally among the seven measures. The MCP is then awarded a percentage (0-100) of the bonus amount allotted to each measure. This determination is made on a measure by measure basis, using the MCP's performance measure result in comparison to a set of ten performance levels, and corresponding standards, established for each measure. MCPs failing to meet the standard for level one are awarded 0% for the measure. The P4P measures and corresponding standards for the ten performance levels are provided in Table 2. below. Each measure's Minimum Performance Standard, as set forth in Appendix M, is provided for comparative purposes only.

Table 2. SFY 2016 P4P Measures and Performance Bonus Payment Standards

Quality Strategy Priority: Effective and Efficient Healthcare Administration ***Goal: Sustain a Quality Focused Organization*** **Quality Strategy Focus Area – Pay for Performance (P4P)**							
SFY 2016 P4P Measures and Performance Bonus Payment Standards							
	Standards that Determine % of Bonus Amount Awarded, by Measure						

P4P Perf. Level	**Percent of Bonus Amount Awarded**	Follow-Up After Hospital-ization for Mental Illness (7 Days)	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal and Postpartum Care: Postpartum Care	Controlling High Blood Pressure (Patients with Hyper-tension)	Adolescent Well-Care Visits	Appropriate Treatment for Children With Upper Respiratory Infection	Compre-hensive Diabetes Care: HbA1c Control (<8.0%)
10	100%	54.5%	89.6%	69.5%	63.8%	59.2%	91.2%	52.9%
9	87%	52.0%	88.6%	68.1%	62.3%	57.1%	90.2%	51.6%
8	74%	49.6%	87.5%	66.8%	60.8%	54.9%	89.2%	50.3%
7	61%	47.2%	86.4%	65.5%	59.4%	52.8%	88.2%	49.0%
6	50%	44.7%	85.4%	64.2%	57.9%	50.7%	87.1%	47.7%
5	39%	42.3%	84.3%	62.8%	56.5%	48.5%	86.1%	46.4%
4	28%	40.2%	83.0%	61.5%	54.9%	47.1%	85.2%	44.8%
3	19%	38.1%	81.7%	60.2%	53.3%	45.8%	84.3%	43.1%
2	11%	35.9%	80.4%	58.8%	51.7%	44.4%	83.4%	41.5%
1	4%	33.8%	79.1%	57.5%	50.1%	43.1%	82.5%	39.8%
	0%	≤33.7%	≤ 79.0%	≤ 57.4 %	≤ 50.0%	≤ 43.0%	≤82.4%	≤ 39.7%
MPS		31.7%	77.8%	56.2%	48.6%	41.7%	81.6%	38.2%

MPS = Minimum Performance Standard (*established in Appendix M, and provided above for reference*)

Note: The measurement year for the seven SFY 2016 P4P measures is CY 2015. MCP performance is assessed using MCP self-reported, audited HEDIS data calculated in accordance with *NCQA HEDIS 2016, Volume 2: Technical Specifications.*

1.b.ii. Quality Improvement

The P4P Incentive System measures are aligned with the ODM Quality Strategy and thus 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 MCP quality improvement, ODM will require each MCP to develop and implement one Quality Improvement Project (QIP), as outlined in paragraph 3.a. of Appendix K, for each MCP SFY 2016 P4P measure result that does not meet the corresponding standard listed below. The MCP must adhere to ODM-specified reporting and submission guidelines in completing the QIP.

Follow-Up After Hospitalization for Mental Illness (7 Days)	TBD
Prenatal and Postpartum Care: Timeliness of Prenatal Care	TBD
Prenatal and Postpartum Care: Postpartum Care	TBD
Controlling High Blood Pressure (Patients with Hypertension)	TBD
Adolescent Well-Care Visits	TBD
Appropriate Treatment for Children with Upper Respiratory Infection	TBD
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	TBD

1.c. SFY 2017 P4P

1.c.i. Determination

For SFY 2017, ODM will calculate a 'bonus amount' for each participating MCP that is equal to 1.25% of the net premium and delivery payments made to the MCP between January 1, 2016 and December 31, 2016 pursuant to the applicable Medicaid Managed Care Provider Agreements. Each participating MCP may be awarded a performance bonus payment of up to 100% of the MCP's bonus amount.

Performance is assessed on seven measures. The MCP's total bonus amount is divided equally among the seven measures. The MCP is then awarded a percentage (0-100) of the bonus amount allotted to each measure. This determination is made on a measure by measure basis, using the MCP's performance measure result in comparison to a set of ten performance levels, and corresponding standards, established for each measure. MCPs failing to meet the standard for level one are awarded 0% for the measure. The P4P measures and corresponding standards for the ten performance levels are provided in Table 2. below. Each measure's Minimum Performance Standard, as set forth in Appendix M, is provided for comparative purposes only.

Table 2. SFY 2017 P4P Measures and Performance Bonus Payment Standards

Quality Strategy Priority: Effective and Efficient Healthcare Administration ***Goal: Sustain a Quality Focused Organization*** **Quality Strategy Focus Area – Pay for Performance (P4P)**								
SFY 2017 P4P Measures and Performance Bonus Payment Standards								
		Standards that Determine % of Bonus Amount Awarded, by Measure						
P4P Perf. Level	**Percent of Bonus Amount Awarded**	Follow-Up After Hospital-ization for Mental Illness (7 Days)	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal and Postpartum Care: Postpartum Care	Controlling High Blood Pressure (Patients with Hyper-tension)	Adolescent Well-Care Visits	Appropriate Treatment for Children With Upper Respiratory Infection	Compre-hensive Diabetes Care: HbA1c Control (<8.0%)
10	100%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
9	87%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
8	74%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
7	61%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
6	50%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
5	39%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
4	28%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
3	19%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
2	11%	TBD	TBD	TBD	TBD	TBD	TBD	TBD

1	4%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	0%	TBD	TBD	TBD	TBD	TBD	TBD	TBD
MPS		TBD	TBD	TBD	TBD	TBD	TBD	TBD

MPS = Minimum Performance Standard (*established in Appendix M, and provided above for reference*)

Note: The measurement year for the seven SFY 2017 P4P measures is CY 2016. MCP performance is assessed using MCP self-reported, audited HEDIS data calculated in accordance with *NCQA HEDIS 2017, Volume 2: Technical Specifications.*

1.c.ii. Quality Improvement

The P4P Incentive System measures are aligned with the ODM Quality Strategy and thus 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 MCP quality improvement, ODM will require each MCP to develop and implement one Quality Improvement Project (QIP), as outlined in paragraph 3.a. of Appendix K, for each MCP SFY 2017 P4P measure result that does not meet the corresponding standard listed below. The MCP must adhere to ODM-specified reporting and submission guidelines in completing the QIP.

Follow-Up After Hospitalization for Mental Illness (7 Days)	TBD
Prenatal and Postpartum Care: Timeliness of Prenatal Care	TBD
Prenatal and Postpartum Care: Postpartum Care	TBD
Controlling High Blood Pressure (Patients with Hypertension)	TBD
Adolescent Well-Care Visits	TBD
Appropriate Treatment for Children with Upper Respiratory Infection	TBD
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	TBD

2. NOTES

2.a. Timing of P4P Incentive System Determination

ODM will issue the annual P4P Incentive System determination to participating MCPs within six months of the end of the contract period. Given that unforeseen circumstances may impact the timing of this determination, ODM reserves the right to revise the time frame in which the P4P Incentive System determination is issued (i.e., the determination may be made more than six months after the end of the contract period).

2.b. Provider Agreement Termination, Nonrenewal, or Denial

Upon termination, nonrenewal, or denial of an MCP Provider Agreement, the bonus amount in the managed care program performance payment fund will be retained or awarded by ODM, in accordance with Appendix P, *MCP Termination/Non-renewal,* of this Provider Agreement.

2.c. P4P Measures and Measurement Years

ODM reserves the right to revise P4P measures and measurement years, as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's overall performance level for that contract period.

2.d. HEDIS Measure Rotation

MCPs may not report rotated measure results, per NCQA methodology, for any HEDIS measure and measurement year listed in this Appendix.

2.e. P4P Bonus Amounts – Status Determination

In the event an MCP's performance cannot be evaluated on a particular P4P measure, ODM in its sole discretion will award or retain 100% of the bonus amount allocated to that particular measure. This determination will be based on the circumstances involved (e.g., for SFY 2016, if the measure was assigned an audit result of "Not Report" on the MCP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCP, ODM will retain 100% of the bonus amount allocated to that measure).

2.f. P4P Performance Standards – Retrospective Adjustment

ODM uses a uniform methodology, as needed, for the retrospective adjustment of any P4P Performance Bonus Payment Standard listed in Section 1. of this Appendix. This methodology will be implemented at ODM's sole discretion when all three of the following criteria are met.

- *The methodology for the standard's associated measure is revised.* Note, for HEDIS measures, ODM will not adjust performance measure standards retrospectively due to procedural changes such as revisions to medical record hybrid review timelines.

- *For the year the methodology is revised, the performance results for all Ohio Medicaid MCPs all increase or all decrease when compared to the standard setting year* (e.g., for the SFY 2013 provider agreement, the standard setting year is HEDIS 2011). Note, this excludes MCPs without results for both years.

- *For the year the methodology is revised, the performance results for three or more Ohio Medicaid MCPs each change by at least three percentage points (e.g., increase from 56.0% to 59.0%) when compared to the standard setting year*.

For a comprehensive description of the standard adjustment methodology, see *ODM Methods for the Retrospective Adjustment of Quality and P4P Measure Standards.*

APPENDIX P

MCP TERMINATION/NONRENEWAL

1 . MCP-INITIATED TERMINATIONS/NONRENEWALS

If an MCP provides notice of the termination/nonrenewal of their provider agreement to ODM, pursuant to Article VIII of the agreement, the MCP will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

MCP agrees to fulfill all duties and obligations as required under Chapter 5160-26 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCP does not submit all outstanding monies owed and

required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement, the monetary assurance will not be refunded to the MCP.

c Bonus Amount

The bonus amount in the managed care program performance payment fund will be retained by ODM.

d. Final Accounting of Amounts Outstanding

MCP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to MCP. ODM payment will be limited to only those amounts properly owed by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. Data Files

In order to assist members with continuity of care, the MCP must create data files to be shared with each newly enrolling MCP. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.

g. Notification

i. Provider Notification - The MCP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.

ii. Member Notification – Unless otherwise notified by ODM, the MCP must notify their members regarding their provider agreement termination at least 45 days in advance of the effective date of termination. The member notification must be approved by ODM prior to distribution.

iii. Prior Authorization Re-Direction Notification - The MCP must create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of

termination; this notice will direct members and providers to contact the enrolling MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCP must utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.

2. ODM-INITIATED TERMINATIONS FOR CAUSE UNDER OAC 5160-26-10

a. If ODM initiates the proposed termination, nonrenewal or amendment of this Provider Agreement pursuant to OAC rule 5160-26-10 by issuing a proposed adjudication order pursuant to O.R.C. 5164.38, and the MCP submits a valid appeal of that proposed action pursuant to O.R.C. Chapter 119, the MCP's provider agreement will be extended through the issuance of an adjudication order in the MCP's appeal under ORC Chapter 119.

   During this time, the MCP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation under Appendix N of the provider agreement. If the MCP exceeds 69 points, each subsequent point accrual will result in a $15,000 nonrefundable fine.

   Pursuant to OAC rule 5160-26-10(H), if ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODM may notify the MCP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCP without cause. If ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODM may propose to terminate the membership of all of the MCP's members. The appeal process for reconsideration of the proposed termination of members is as follows:

   - All notifications of such a proposed MCP membership termination will be made by ODM via certified or overnight mail to the identified MCP Contact.

   - MCPs notified by ODM of such a proposed MCP membership termination will have three working days from the date of receipt to request reconsideration.

   - All reconsideration requests must be submitted by either facsimile transmission or overnight mail to the Director, Ohio Department of Medicaid, and received by 3PM Eastern Time on the third working day following receipt of the ODM notification of termination. The address and fax number to be used in making these requests will be specified in the ODM notification of termination document.

   - The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests must explain in detail why the proposed MCP membership termination is not justified. The MCP's justification for reconsideration will be limited to a review of the written material submitted by the MCP.

- A final decision or request for additional information will be made by the Director within three working days of receipt of the request for reconsideration. Should the Director require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.

- The proposed MCP membership termination will not occur while an appeal is under review and pending the Director's decision. If the Director denies the appeal, the MCP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODM determines that it would be in the best interest of the members.

b. Fulfill Existing Duties and Obligations

MCP agrees to fulfill all duties and obligations as required under Chapter 5160-26 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

c. Refundable Monetary Assurance

The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCP's next month's capitation payment until such time that ODM receives documentation

that the monetary assurance is received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement, the monetary assurance will not be refunded to the MCP.

d. Bonus Amount

The bonus amount in the managed care program performance payment fund will be retained by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. Final Accounting of Amounts Outstanding

MCP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to MCP. ODM payment will be limited to only those amounts properly owed by ODM.

g. Data Files

In order to assist members with continuity of care, the MCP must create data files to be shared with each newly enrolling MCP. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.

h. Notification

i. Provider Notification - The MCP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.

ii. Prior Authorization Re-Direction Notification - The MCP must create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCP must utilize

ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.

3. TERMINATION DUE TO NON-SELECTION THROUGH ODM PROCUREMENT PROCESSES

Should this Provider Agreement end or not be extended in the event MCP is not awarded a provider agreement as a result of an ODM procurement and MCP selection process pursuant to OAC rule 5160-26-04, MCP has no right to appeal the selection process under ORC Chapter 119 pursuant to ORC 5164.38 and will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

MCP agrees to fulfill all duties and obligations as required under Chapter 5160-26 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCP's next month's capitation payment until such time that ODM receives documentation

that the monetary assurance is received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement, the monetary assurance will not be refunded to the MCP.

c. Bonus Amount

The bonus amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.

d. Monetary Sanctions

All previously collected refundable monetary sanctions shall be returned to the MCP.

e. Final Accounting of Amounts Outstanding

MCP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to MCP. ODM payment will be limited to only those amounts properly owed by ODM.

f. Data Files

In order to assist members with continuity of care, the MCP must create data files to be shared with each newly enrolling MCP. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The terminating MCP will be responsible for ensuring the accuracy and data quality of the files.

g. Notification

a. Provider Notification - The MCP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.

b. Prior Authorization Re-Direction Notification - The MCP must create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior

authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCP must utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCP membership.

4. TERMINATION OR MODIFICATION OF THIS PROVIDER AGREEMENT DUE TO LACK OF FUNDING

Should this Provider Agreement terminate or be modified due to a lack of available funding as set forth in the Baseline of this Agreement, MCP has no right to appeal the selection process under ORC Chapter 119 pursuant to ORC 5164.38 and will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

MCP agrees to fulfill all duties and obligations as required under Chapter 5160-26 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population(s) during periods of time when MCP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCP of any previously reported appeals and grievances data which were unresolved for the Medicaid populations, resolution of provider and consumer complaints for the Medicaid population served by the MCP for the MCP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCP for the MCP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCP will be required to submit a refundable monetary assurance should the Provider Agreement terminate. This monetary assurance will be held by ODM until such time that the MCP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODM in the month the termination notice is issued, whichever is greater.

The MCP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCP must contact their Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance is received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, fines or sanctions, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement, the monetary assurance will not be refunded to the MCP.

c. Bonus Amount

The bonus amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.

d. Monetary Sanctions

Previously collected refundable monetary sanctions directly and solely related to the termination or modification of this Provider Agreement shall be returned to the MCP.

e. Final Accounting of Amounts Outstanding

MCP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after a termination/nonrenewal date of this Provider Agreement. Failure by the MCP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to MCP. ODM payment will be limited to only those amounts properly owed by ODM.

f. Data Files

In order to assist members with continuity of care, the MCP must create data files if requested by ODM. The data files will be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, and pregnant members. The timeline for providing these files will be at the discretion of ODM. The MCP will be responsible for ensuring the accuracy and data quality of the files.

g. Provider Notification

The MCP must notify contracted providers within 30 days of notice from ODM of the effective date of termination or modification of this Provider Agreement. The provider notification must be approved by ODM prior to distribution.

APPENDIX Q

PAYMENT REFORM

I. Introduction.

On January 9, 2013, Governor John Kasich's Advisory Council on Health Care Payment Reform adopted the Catalyst for Payment Reform (CPR) principles as part of a comprehensive strategy to prioritize and coordinate multi-payer health care payment innovation activities in Ohio. The Ohio Department of Medicaid (ODM) is committed to reforming the health care delivery system by designing and implementing systems of payment that signal powerful expectations for improved health care delivery. As such the following principles have been adopted by Ohio Medicaid:

1. Payment reforms should promote health by rewarding the delivery of quality, cost effective and affordable care that is patient-centered and reduces disparities.

2. Health care payments should encourage and reward patient-centered care that coordinates services across the spectrum of providers and care setting while tailoring health care service to the individuals patient's needs.

3. Payment policies should encourage alignment between public and private sectors to promote improvement, innovations and meeting national health priorities, and to maximize the impact of payment decisions of one sector on the other.

4. Decisions about payment should be made through independent processes that are guided by what serves the patient and helps society as a whole, and payment decisions must balance the perspectives of consumers, purchasers, payers, physicians and other health care providers.

5. Payment policies should foster ways to reduce expenditure on administrative processes (e.g., claims payment and adjudications).

6. Reforms to payment should balance the need for urgency against the need to have realistic goals and timelines that take into account the need to change complex systems and geographic and other variations.

In order to improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, there must be significant changes in existing payment structures and methodologies as well as the environment in which payments are made. This Appendix outlines ODM's expectations for how MCP shall achieve progress in the following areas:

A. **Value-Oriented Payment:** MCP shall design and implement payment methodologies with its network providers that are designed either to cut waste or reflect value. For the purposes of this Provider Agreement, payments that cut waste are those that by their design reduce unnecessary payment and unnecessary care (e.g. elective cesarean deliveries). Value is defined as the level of the quality of care for the amount of money paid to the provider. Payments designed to reflect value are those that are tied to provider performance so that they may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.

B. **Market Competition and Consumerism:** MCP shall design contracting methodologies and payment options and administer the benefit package to members in a manner that enhances competition among providers and reduces unwarranted price and quality variation. To stimulate provider competition further, MCP shall establish programs to engage MCP members to make informed choices and to select evidence-based, cost-effective care.

C. **Transparency:** MCP shall participate in ODM initiatives to design and implement member-accessible comparisons of provider information including quality, cost, and patient experience, among providers in the plan's network. The MCP shall contribute to the program design, provide data as specified by ODM, and publish results in accordance with standards established by the Department.

These commitments are included to support and advance MCP initiatives to develop a health care market where (a) payment increasingly is designed to improve and reflect the effectiveness and efficiency with which providers deliver care, and (b) consumers are engaged in managing their health, selecting their providers, and sensitive to the cost and quality of services they seek. The term "provider" is defined in OAC rule 5160-26-01. The MCP must use its best efforts to ensure that these commitments and initiatives apply to the benefits offered and services provided under this Provider Agreement and administered by the MCP.

II. Obligations of MCP

A. VALUE-ORIENTED PAYMENT, MARKET COMPETITION & CONSUMERISM

MCP shall implement payment strategies that tie payment to value or reduce waste, as those terms are defined herein. In doing so, MCP shall, on or before July 1, 2013**,** provide ODM with its strategy to make 20% of aggregate net payments to providers value-oriented by 2020. Examples of strategies include the following:

1. Pay providers differentially according to performance (and reinforce with benefit design).

2. Design approaches to payment that cut waste while not diminishing quality, including reducing unwarranted payment variation.

3. Payments designed to encourage adherence to clinical guidelines. At a minimum, MCPs must address policies to discourage elective deliveries before 39 weeks.

4. Payment strategies to reduce unwarranted price variation, such as reference or value pricing (e.g. analysis of price variation among network providers by procedure and service types, pilot value pricing programs, encouragement of member value-based pricing information , center of excellence pricing, and rebalance payment between primary and specialty care).

B. The Current SIM Project

In February 2013, Ohio was awarded a federal State Innovation Model (SIM) grant to design payment models that increased access to patient-centered medical homes and support episode-based payments for acute medical event. The purpose of both models is to achieve better health, better care, and cost savings through improvement. Medicaid is a major participant in the project and the involvement of the MCP is important to the success of these models. ODM expects the MCP's participation in the State Innovation Model (SIM) project.

III Reporting

MCPs must submit a quarterly progress report as specified by ODM that addresses progress towards meeting the obligations as outlined in II above.