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

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

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

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

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

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

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

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

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

ARTICLE I - GENERAL

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

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

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

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

ARTICLE II - TIME OF PERFORMANCE

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

ARTICLE III - REIMBURSEMENT

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

ARTICLE IV - RELATIONSHIP OF PARTIES

A. ODM and the MCOP agree that, during the term of this Agreement, the MCOP shall be engaged with ODM solely on an independent contractor basis, and neither the MCOP nor its personnel shall, at any time or for any purpose, be considered as agents, servants or employees of ODM or the state of Ohio. The MCOP shall therefore be responsible for all the MCOP's business expenses, including, but not limited to, employee's wages and salaries, insurance of every type and description, and all business and personal taxes, including income and Social Security taxes and contributions for Workers' Compensation and Unemployment Compensation coverage, if any.

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

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

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

ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS

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

B. The MCOP represents, warrants, and certifies that it and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws. The MCOP further represents, warrants, and certifies that neither the MCOP nor any of its employees will do any act or omit any action that is inconsistent with such laws.

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

D. Any such person who acquires an incompatible, compromising or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, shall immediately disclose his or her interest to ODM in writing. Thereafter, he or she shall not participate in any action affecting the services under this Provider Agreement, unless ODM shall determine in its sole discretion that, in the light of the personal interest disclosed, his or her participation in any such action would not be contrary to the public interest. The written disclosure of such interest shall be made to: Chief, BMC, ODM.

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

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

ARTICLE VI - NONDISCRIMINATION OF EMPLOYMENT

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

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

C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5160-58, the MCOP agrees to hold all subcontractors and persons acting on behalf of the MCOP in the performance of services under this Provider Agreement responsible for adhering to the requirements of paragraphs (A) and (B) above and shall include the requirements of paragraphs (A) and (B) above in all subcontracts for services performed under this Provider Agreement, in accordance with OAC rules 5160-58-01.1 and 5160-26-05.

ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION

A. The MCOP agrees that all records, documents, writings or other information produced by the MCOP under this Provider Agreement and all records, documents, writings or other information used by the MCOP in the performance of this Provider Agreement shall be treated in accordance with OAC rules 5160-58-01.1 and 5160-26-06 and must be provided to ODM, or its designee, if requested. The MCOP must maintain an appropriate record system for services provided to members. The MCOP must retain all records in accordance with 45 CFR 74.53.

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

C. The MCOP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this Provider Agreement. The MCOP agrees to be bound by the same standards of confidentiality that apply to the employees of ODM and the State of Ohio, including without limitation the confidentiality

requirements found in 42 CFR Part 431 Subpart F and ORC 5160.45, as well as 42 C.F.R. 2.12 and ORC 5119.27, as applicable. The terms of this section shall be included in any subcontracts executed by the MCOP for services under this Provider Agreement. The MCOP must implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

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

E. All records relating to performance, under or pertaining to this Provider Agreement will be retained by the MCOP in accordance to the appropriate records retention schedule. The appropriate records retention schedule for this Provider Agreement is for a total period of eight (8) years. For the initial three (3) years of the retention period, the records must be stored in a manner and place that provides readily available access. If any records are destroyed prior to the date as determined by the appropriate records retention schedule, the MCOP agrees to pay to ODM all damages, costs, and expenses incurred by ODM associated with any cause, action or litigation arising from such destruction.

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

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

ARTICLE VIII - NONRENEWAL AND TERMINATION

A. This Provider Agreement may be terminated, pursuant to Section 5.5 of the Three-Way or by ODM or the MCOP upon written notice in accordance with the applicable rule(s) of the OAC, with termination to occur at the end of the last day of the termination month. If the Three-Way is terminated, and ODM decides to enter into a new Provider Agreement with the MCOP, MCOP shall be required to enter into a new Provider

Agreement with ODM that shall begin the day after the termination of the Three-Way. By executing this Agreement, MCOP expressly agrees to be bound by this provision of the Agreement. If the option to enter into a new Provider Agreement per this Section is exercised, the MCOP will be provided a copy of the proposed new Provider Agreement for review prior to execution. The terms of the new Provider Agreement will not be unconscionable or capricious and the parties agree to negotiate in good faith.

B. This Provider Agreement shall automatically terminate on April 16, 2014, if the Three-Way is not executed by April 15, 2014. At ODM's discretion, MCOP shall enter into a new Provider Agreement with ODM in a form as prescribed by ODM. By executing this Agreement, MCOP expressly agrees to be bound by this provision of the Agreement. If the option to enter into a new Provider Agreement per this Section is exercised, the MCOP will be provided a copy of the proposed new Provider Agreement for review prior to execution. The terms of the new Provider Agreement will not be unconscionable or capricious and the parties agree to negotiate in good faith.

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

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

E. In the event of termination under this Article, MCOP shall return all records in their native format relating to cost, work performed, supporting documentation for invoices submitted to ODM, and copies of all materials produced under or pertaining to this Provider Agreement.

F. ODM may, in its sole discretion, terminate or fail to renew this Provider Agreement if the MCOP or MCOP's subcontractors violate or fail to comply with the provisions of this Agreement or other provisions of law or regulation governing the Medicaid program. Where ODM proposes to terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the OAC with respect to ODM's suspension, termination or refusal to enter into a provider agreement may apply Pursuant to ORC 5164.38, the MCOP does not have the right to request an adjudication hearing under Chapter 119 of the ORC to challenge any action taken or decision made by ODM with

respect to entering into or refusing to enter into a provider agreement with the MCOP pursuant to section 5167.10 of the Revised Code.

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

ARTICLE IX - AMENDMENT AND RENEWAL

A. This Provider Agreement may be amended only by a writing signed by both parties. Any written amendments to this Provider Agreement shall be prospective in nature.

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

ARTICLE X - LIMITATION OF LIABILITY

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

B. The MCOP hereby agrees to be liable for any loss of federal funds suffered by ODM for enrollees resulting from specific, negligent acts or omissions of the MCOP or its

subcontractors during the term of this Agreement, including but not limited to the nonperformance of the duties and obligations to which the MCOP has agreed under this Agreement.

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

D. In no event shall ODM be liable for indirect, consequential, incidental, special or punitive damages, or lost profits.

ARTICLE XI - ASSIGNMENT

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

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

ARTICLE XII - CERTIFICATION MADE BY THE MCOP

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

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

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

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

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

F. The MCOP certifies and affirms that, as applicable to the MCOP, that no party listed or described in Division (I) or (J) of Section 3517.13 of the ORC who was in a listed position at the time of the contribution, has made as an individual, within the two

previous calendar years, one or more contributions in excess of one thousand and 00/100 ($1,000.00) to the present governor or to the governor's campaign committees during any time he/she was a candidate for office. This certification is a material representation of fact upon which reliance was placed when this Provider Agreement was entered into. If it is ever determined that the MCOP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, the MCOP shall return to ODM all monies paid to the MCOP under this Provider Agreement. The provisions of this section shall survive the expiration or termination of this Provider Agreement.

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

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

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

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

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

ARTICLE XIII - CONSTRUCTION

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

ARTICLE XIV - INCORPORATION BY REFERENCE

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

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

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

ARTICLE XV – NOTICES

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

ARTICLE XVI – HEADINGS

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

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

INSERT MCOP NAME

BY: _____ DATE: _____
INSERT TITLE

INSERT 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)
MyCare Ohio Provider Agreement
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July 1, 2014
Amended January 1, 2015

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

The managed care program rules can be accessed electronically through the Medicaid Managed Care page of the Ohio Department of Job and Family Services website, until such time as the ODM website is available.

APPENDIX B

SERVICE AREA SPECIFICATIONS

MY CARE OHIO PLAN:

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

Service Area Regions

Central ☐

East Central ☐

Northeast ☐

Northeast Central ☐

Northwest ☐

West Central ☐

Southwest ☐

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

OHIO MY CARE OHIO PLAN SERVICE AREA REGIONS BY COUNTY

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

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

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

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

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

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

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

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

APPENDIX C

MYCARE OHIO PLAN RESPONSIBILITIES

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

General Provisions

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

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

3. The MCOP must designate the following:

   a. A primary contact person, the Contract Compliance Officer, as specified in Sections 2.2.2.1 and 2.2.3.4.1.3 of the Three-Way Contract between MCOP, CMS and ODM (Three-Way), who will dedicate a majority of his or her time to the MyCare Ohio (Medicaid-Medicare) product line and coordinate overall communication between ODM and the MCOP. ODM may also require the MCOP to designate contact staff for specific program areas. The Contract Compliance Officer will be responsible for ensuring the timeliness, accuracy, completeness and responsiveness of all MCOP submissions to ODM.

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

4. Communications: The MCOP must comply with all aspects of Section 2.2 of the Three-Way. In addition, the MCOP must take all necessary and appropriate steps to ensure that all MCOP staff are aware of, and follow, the following communication process:

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

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

   c. Because the MCOP is ultimately responsible for meeting program requirements, ODM will not discuss MCOP issues with the MCOP's subcontractor unless the

MCOP is also participating in the discussion. MCOP subcontractors, with the MCOP participating, should only communicate with the specific Contract Administrator assigned to that MCOP.

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

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

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

8. The MCOP must have the key MyCare Ohio Medicaid Managed Care program staff specified in Section 2.2.3 of the Three-Way based and working in the state of Ohio. Each key staff person identified in Section 2.2.3 of the Three-Way may occupy no more than one of the positions, unless the MCOP receives prior written approval from ODM stating otherwise.

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

10. The MCOP must have all new employees trained on applicable program requirements including those in the Three-Way, and represent, warrant and certify to ODM that such training occurs, or has occurred. Plans must conduct staff training sessions on subjects including disability competency, access, cultural sensitivity, person-centered care delivery approaches and independent living philosophies.

11. All employees of the MCOP and the MCOP's delegated/subcontracted entities who have in-person contact with members in their home must comply with criminal record check requirements as specified by ODM.

12. The MCOP must follow requirements related to moral or religious objections in the Three-Way as specified in Section 5.1.12. If an MCOP determines that it does not wish to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, it must immediately notify ODM to coordinate the implementation of this change. The MCOP will be required to notify its members of this change at least thirty (30) days prior to the effective date. The MCOP's member handbook and provider directory, as well as all marketing materials, will need to include information specifying any such services that the MCOP will not provide.

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

14. The MCOP is responsible for determining medical necessity for services and supplies requested for their members as specified in OAC rule 5160-58-03. Notwithstanding such responsibility, ODM retains the right to make the final determination on medical necessity in specific member situations.

15. In addition to the timely submission of medical records at no cost for the annual external quality review as specified in OAC rules 5160-58-01.1 and 5160-26-07, the MCOP may be required for other purposes to submit medical records at no cost to ODM and/or its designee upon request.

16. In addition to complying with the requirements in OAC rules 5160-58-01.1 and 5160-26-05, the MCOP must notify the BMC within 1 working day of becoming aware of the termination of an MCOP panel provider if that provider is designated as the primary care provider (PCP) for either 100 or more of the MCOP's members. The MCOP must also follow the requirements set forth in 2.6.1.2 of the Three-Way regarding notification of changes to the MCOP's provider network.

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

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

    a. The MCOP 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 MCOP pursuant to OAC rule 5160-58-03 and Appendix G of this Provider Agreement. If the MCOP offers transportation to its members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.

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

c. The MCOP must give ODM and members ninety (90) days prior notice when decreasing or ceasing any additional benefit(s). When an MCOP finds that it is impossible to provide 90 days prior notice for reasons beyond its control, as demonstrated to ODM' satisfaction, ODM must be notified within at least one (1) working day.

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

20. Comprehensive Disaster/Emergency Response Planning
The MCOP must develop and implement an 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 MCOP must notify its Contract Administrator immediately when the Comprehensive Disaster/Emergency Response Plan has been activated. The MCOP must make a current version of the approved Comprehensive Disaster/Emergency Plan available to all staff.

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

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

Individual Disaster/Emergency Response Plan

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

21. The MCOP must comply with any applicable federal and state laws that pertain to member rights and ensure that its staff adheres to such laws when furnishing services to its members. The MCOP shall include a requirement in its contracts with affiliated providers that such providers also adhere to applicable Federal and State laws when providing services to members.

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

23. Marketing Materials and Member Materials

Pursuant to OAC rules 5160-58-01.1, 5160-26-08 and 5160-26-08.2, the MCOP is responsible for ensuring that all MCOP marketing and member materials are prior approved by ODM before being used or shared with members or potential members. Member materials must be available in written format, but can be provided to the member in alternative formats (e.g., CD-ROM) if specifically requested by the member, except as specified in OAC rule 5160-58-08.4. Marketing and member materials are defined as follows:

a. Marketing materials are those items produced in any medium, by or on behalf of an MCOP, including gifts of nominal value (i.e., items worth no more than $15.00), which can reasonably be interpreted as intended to market to eligible individuals as defined in OAC 5160-58-01.

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

c. MCOP marketing and member materials must not include statements that are

inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODM.

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

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

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

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

h. The MyCare Ohio logo must be on all member and marketing materials.

24. <u>Cultural Competency and Communication Needs</u>

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

The MCOP must comply with the requirements specified in Section 2.12 of the Three-Way for member communication standards and must comply with OAC rules 5160-58-01.1, 5160-26-03.1, 5160-26-05, 5160-26-05.1, 5160-26-08 and 5160-26-08.2 for

providing assistance to LEP members and eligible individuals. In addition, the MCOP must provide written translations of certain MCOP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

a. If ODM identifies prevalent common primary languages other than English in the MCOP's service area, the MCOP, as specified by ODM, must translate marketing and member materials into the primary languages of those groups. In addition, the MCOP must make these marketing and member materials available to eligible individuals free of charge.

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

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

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

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

e. <u>Person-Centered Language in Communications</u> - The MCOP will use person-centered language in all communication with eligible individuals and members

consistent with the definition available at: http://www.disabilityisnatural.com/explore/professionals-organizations.

f. MCOP HIPAA privacy notices must be translated into other languages pursuant to Ohio Marketing Guidance and Title VI of the Civil Rights Act. MCOPs must also assess member primary languages and provide materials in other prevalent languages.

25. Issuance of Member Materials

The MCOP must provide members with a variety of materials, including at a minimum those specified in the OAC rules, this Provider Agreement and the Three Way. The following provides clarification regarding the issuance of specific member materials.

a. New Member Materials - Pursuant to OAC rules 5160-58-01.1 and 5160-26-08.2, MCOPs must provide to each member who selects or changes MCOPs, or changes Medicaid-only or dual benefit status, an MCOP identification (ID) card, a new member letter, a member handbook (including a waiver handbook if applicable), and provider panel information, as specified by ODM.

i. The MCOP must use the model language specified by ODM and/or CMS for the new member letter and member handbooks.

ii. The MCOP must mail ID cards to each member via a method that will ensure receipt no earlier than 15 days prior to the member's effective date of coverage and no later than the day prior to the member's effective date of coverage.

a. An MCOP will meet the timeliness requirement for mailing ID cards to members who select or change MCOPs, or change Medicaid-only or dual benefit status within the five days prior to the end of the month, if the ID cards are mailed within:

i. Five (5) working days of the MCOP receiving the ODM produced HIPAA 834C that lists the individual as a Medicaid-only member; or

ii. Ten (10) working days of the MCOP receiving the ODM-produced HIPAA 834C that lists the individual as a dual benefits member.

b. The MCOP ID card must contain pharmacy information, and the toll-free 24-hour behavioral health crisis and care management telephone numbers as prescribed by ODM.

c. For Medicaid Only members when a contracted primary care provider (PCP) is not identified on the consumer contact record (CCR) and the member does not select a PCP, the ID card PCP field must read "Refer to Medicare PCP".

iii. The MCOP must mail the new member letter and member handbook, including the waiver handbook if applicable, separate from the ID card. An MCOP will meet the timeliness requirement for mailing these materials if they are mailed to members within five (5) working days of the MCOP receiving the ODM produced HIPAA 834C, that lists the individual as a new member.

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

a. MCOPs may mail ODM prior-approved provider directory notices to all new members in lieu of mailing printed directories. The notices must be mailed with the member materials specified in 25.a.iii of this Appendix and, at a minimum, advise members they can call the MCOP to request printed provider directories and access the information on the MCOP's website.

b. MCOPs that mail ODM prior-approved provider directory notices to new members in lieu of mailing printed directories must automatically send printed provider directories to members that voluntarily enroll and request printed provider directories, as reflected on the Consumer Contact Record (CCR). Printed directories must be mailed with the new member materials specified in 25.a.iii of this Appendix.

c. MCOPs that do not use an ODM prior-approved provider directory notice must mail printed provider directories to all new members with the member materials specified in 25.a.iii of this Appendix except printed provider directories do not need to be mailed to new members that voluntarily enroll and request to not receive printed provider directories as reflected on the CCR.

d. When a member requests a printed provider directory as a result of provider directory notices or after initial months of enrollment, the printed provider directory must be sent to the member within seven (7) calendar days of the request.

v. Waiver Material

a. <u>Annual material</u> – The MCOP must issue waiver handbooks annually to members enrolled in the MyCare Ohio waiver. The MCOP is responsible for ensuring that each MyCare Ohio Integrated Care (IC) Waiver enrollee receives the Waiver Member Handbook at the time of enrollment, and also at the time of each annual reassessment. The MCOP is responsible for ensuring that the Waiver Care Manager or Waiver Service Coordinator has verbally reviewed the content of the handbook, and the MCOP shall maintain documentation signed by the enrollee of receipt of this information.

b. Member Waiver Service Freedom of Choice Form – For a member who has chosen waiver services, the MCOP must have an ODM-developed freedom of choice form signed by the member indicating he or she has chosen waiver services over institutional care. This form must be signed at the time that the member enrolls in the waiver. In addition, it must be signed annually thereafter at the time of reassessment of waiver eligibility, closest to the member's level of care redetermination.

c. Self-Direction Handbook - The MCOP will provide an ODM-approved handbook on self-direction detailing processes, etc. to all members directing their own care.

vi. The MCOP must use the model language specified by ODM for the new member letter and as applicable, model language for CMS letters regarding Cancellation of Enrollment and Confirmation of Voluntary Disenrollment Following CMS Daily Transaction Reply Report (DTRR).

26. Healthchek Services

a. Informing Members About Healthchek - In addition to the Healthchek requirements specified in OAC rules 5160-58-03, 5160-58-01.1 and 5160-26-08.2, the MCOP must:

i. Inform each member under the age of 21 within 7 calendar days of their effective date of enrollment in the MCOP about the Healthchek program as prescribed by ODM and as specified by 42 C.F.R. Section 441.56. An MCOP may meet this requirement by including information with the new member materials specified in paragraph 25 of this Appendix. In addition, the MCOP 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 MCOP's member handbooks must be provided to members within the time frames specified in 25.d of this Appendix, and must include verbatim the model language developed by ODM. The model language at a minimum will include:

a. A description of the types of screening and treatment services covered by Healthchek;
b. A list of the intervals at which members under age 21 should receive screening examinations, as indicated by the most recent

version of the document entitled "Recommendations for Preventive Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics;

c. Information that Healthchek services are provided at no additional cost to the member; and

d. Information that providers may request prior authorization for coverage of services that have limitations and/or are not covered for members age 21 and older if the services are medically necessary EPSDT services.

iii. Provide the above Healthchek information in 26.a.ii on the MCOP's member website specified in 42.b. of this Appendix.

iv. Deliver Healthchek information as provided, or as approved, by ODM to the MCOP's members at the following intervals:

a. January of each calendar year to all members under the age of 21; and

b. At the beginning of each school year in the month of July for members under 21.

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 MCOP must populate the materials with appropriate Healthchek information as required (e. g. type of service, rendering provider, date of service and age of member on the date of service).

b. Informing Members about Pregnancy Related Services (PRS)

i. Upon the identification of a member as pregnant, the MCOP must deliver to the member within 14 calendar days a PRS form as designated by ODM. The MCOP 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. <u>Informing Providers about Healthchek</u> -- In addition to the Healthchek requirements specified in OAC rules 5160-58-01.1 and 5160-26-05.1the MCOP must:

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

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

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

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

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

ii. Provide the above information on the MCOP's provider website as specified in 42.c. of this Appendix.

27. Advance Directives

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

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

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

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

a. The member's rights under state law to make decisions concerning his or her medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives

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

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

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

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

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

28. Call Center Standards

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

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

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

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

For the purposes of meeting the staffing requirement for behavioral health crisis services, appropriately qualified health professionals must have experience with behavioral crisis assessment and intervention. The MCOP must ensure that an appropriately qualified health professional is the caller's first point of live contact to answer the call, triage the issue(s), and determine an immediate course of action (e.g., provide intervention, warm transfer to local behavioral health crisis services or care manager). Only one auto-prompt can be used to get the caller to the live contact. Staff must have access to emergency response (e.g., 911, police and fire) and crisis intervention services (pursuant to OAC 5122-29-10 and 3793:2-1-08) in each county in which the plan maintains membership. The MCOP must have arrangements with the county mental health and drug/alcohol crisis lines to assure access to crisis intervention services, and to ensure that contacts with the publicly available or county's crisis line are reported within one business day to the MCOP. The MCOP must document a member's contact with the plan-administered and county-administered behavioral health crisis line in the care management record and ensure follow up by a care manager as soon as warranted but not later than 24 hours from the time the MCOP becomes aware of a member's behavioral health crisis.

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

The MCOP must meet the current American Accreditation HealthCare Commission/URAC-designed Health Call Center Standards (HCC) for call center abandonment rate, blockage rate and average speed of answer for the medical advice, care management support, and the behavioral health crisis 24/7 toll-free call-in systems. If access to these call-in systems is facilitated through the member services line with auto-prompts to transfer the caller, the MCOP must have a process to measure the above call center standards from the time of selecting the auto prompt. If the MCOP uses the member services line to answer the care management support services contacts (i.e., no auto prompt to transfer), then call center standards for the member services line specified in Section 2.9.2.2 of the Three-Way apply. By the 10th of each month, the MCOP must self-report its prior month performance in these three areas for its 24/7 hour toll-free call-in systems to ODM. ODM will inform the MCOPs of any changes/updates to these URAC call center standards.

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

29. <u>Notification of Optional MCOP Membership</u>

In order to comply with the terms of the ODM State Plan Amendment for the managed care program, the MCOP must inform new members that MCOP membership is optional for certain populations.

Specifically, the MCOP must inform any applicable pending members or member that the following population is not required to select an MCOP 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 MCOP:

- Indians who are members of federally-recognized tribes.

Additionally, the MCOP must inform any applicable pending member or member that the following populations are not required to select an MCOP 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 MCOP:

- 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.

30. <u>Privacy Compliance Requirements</u>

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

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

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

160.103. The MCOP, as a Business Associate agrees to comply with all of the following provisions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31. Electronic Communications

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

32. MCOP Membership Acceptance, Documentation and Reconciliation

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

b. Enrollment and Capitation Reconciliation

i. The MCOP shall maintain the integrity of its membership data through reconciliation of the daily HIPAA 834C (Daily Benefit Enrollment and Maintenance File) and the monthly HIPAA 834F (Monthly Benefit Enrollment and Maintenance File) transactions pursuant to ODM instructions. Discrepancies between the HIPAA 834C and 834F that have a negative impact on a member's access to care must be reported to ODM pursuant to ODM instructions.

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

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

c. Change in Enrollment During Hospital/Inpatient Facility Stay - When an MCOP learns of a currently hospitalized member's intent to disenroll through the CCR or the HIPAA 834, the disenrolling MCOP must notify the hospital/inpatient facility and treating providers as well as the enrolling MCOP, if applicable, of the change in enrollment. The disenrolling MCOP must notify the inpatient facility that it

will remain responsible for the inpatient facility charges through the date of discharge; and must notify the treating providers that it will remain responsible for provider charges through the date of disenrollment. The disenrolling MCOP shall not request and/or require that a disenrolled member be discharged from the inpatient facility for transfer to another inpatient facility. Should a discharge and transfer to another inpatient facility be medically necessary, the disenrolling MCOP must notify the treating providers to work with the enrolling MCOP or ODM as applicable to facilitate the discharge, transfer and authorization of services as needed.

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

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

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

e. Newborn Notifications –

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

The MCOP must notify the CDJFS and provide at a minimum the mother's name, social security number, 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 the MCOP have agreed to a different minimum set of information to be transmitted for the CDJFS newborn notification. The MCOP must send this

information within five working days of the birth, or immediately upon learning of the birth.

f. Eligible Individuals (as defined by OAC 5160-58-01) - If an eligible individual contacts the MCOP, the MCOP must provide any MCOP-specific managed care program information requested. The MCOP must not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/transitioning health care services, the MCOP shall provide an assurance that all MCOPs must cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.

g. Pending Member - If a pending member (i.e., an eligible individual subsequent to MCOP selection or assignment to an MCOP, but prior to his or her membership effective date) contacts the selected MCOP, the MCOP must provide any membership information requested, including but not limited to explaining how to access services as an MCOP member and assistance in determining whether current services require prior authorization. The MCOP must also ensure that any care coordination (e.g., PCP selection, prescheduled services and transition of services) information provided by the pending member is logged in the MCOP's system and forwarded to the appropriate MCOP staff for processing as required.

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

33. The MCOP must use ODM-provided historic utilization and prior authorization data files for care coordination/management activities and transition of care requirements.

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

a. Upon a member's initial enrollment in MyCare Ohio, MCOPs must provide transition of Medicare and Medicaid services in accordance with the requirements specified in Section 2.5.4 of the Three-Way for both contracted and non-contracted providers. Non-contracted providers who provide services during the transition of Medicare and Medicaid services specified in Section 2.5.4 of the Three-Way must be paid the Medicaid fee for service (FFS) rate. Prior to the end of any required transition period, the MCOP must inform the member and non-contracted provider of the effective date of any transition to a contracted provider,

during a meeting of the trans disciplinary care team or by another method documented in the care plan.

b. For Medicaid-only members, MCOPs must pay Medicare secondary claims in accordance with the Medicaid FFS methodology, for non-contracted providers of Medicare primary services. MCOPs must provide a method for enrollment of any non-contracted provider who is an enrolled provider with ODM for purposes of Medicaid payment of "crossover" claims pursuant to the CMCS-MMCO-CM Informational Bulletin of June 7, 2013.

c. The MCOP must pay claims for covered services for members enrolled for retroactive periods.

d. MCOPs must contract directly with the Fiscal Management Service (FMS) vendor also under contract with ODM to successfully transition and provide ongoing services for waiver consumers who have elected self-directed employer authority for authorized waiver services. The contract must continue for the entire period of this Provider Agreement.

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

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

g. Member Transition of Care for Prescription Drugs - The MCOP is responsible for implementing transition of care processes that prevent access problems for members that are transitioning from the FFS pharmacy benefit administrator to an MCOP. The transition of care processes for prescription drugs must be consistent the requirements outlined in Medicare Part D.

35. <u>Transition of Care Requirements for Members of an Exiting MCOP</u>
When the enrolling MCOP is informed by ODM, or its designee, of a member transitioning from the exiting MCOP, the enrolling MCOP must follow the transition of care requirements required by ODM.

36. Transition of Care Requirements for Members receiving HCBS Waiver Services who lose MyCare Ohio Eligibility

Upon notification from ODM via the 834, CCR, or other mechanism, and/or another source of information (e.g., waiver service coordinator, member, provider), that a member who is receiving HCBS waiver services and whose enrollment is/may be terminating due to loss of MyCare Ohio eligibility, the MCOP must identify the reason for loss of eligibility and timely assist the member, as appropriate, with maintenance of MyCare Ohio eligibility. Upon confirmation that MyCare Ohio eligibility will be terminated, during the last month of the individual's active membership, the MCOP must facilitate, as appropriate, referrals to programs (e.g., Medicaid waivers) and/or community resources that may assist the individual with continuation of long term services and supports.

37. Transition of Care Requirements for Members receiving HCBS Waiver Services

Upon notification from ODM via the 834, CCR, or other mechanism, and/or another source of information (e.g., waiver service coordinator, member, provider), that a member who is receiving HCBS waiver services and whose enrollment is/may be terminating, the MCOP must identify the reason for termination and timely assist the member, as appropriate, with maintenance of MyCare Ohio eligibility. Upon confirmation on the 834 that MyCare Ohio enrollment will be terminated, during the last month of the individual's active membership, the MCOP must instruct the appropriate local Area Agency on Aging to end ~~assure~~ the MyCare Ohio waiver span at the time of enrollment termination, and facilitate, as appropriate, referrals to programs (e.g., Medicaid waivers) and/or community resources that may assist the individual with continuation of needed long term services and supports. When a referral is made to a Medicaid waiver program, the MCOP must provide the MyCare Ohio waiver service plan and any identified service issues or follow-up necessary to successfully transfer care to the waiver care management agency.

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

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

39. Transition of Care Requirements for Members who are changing MyCare Ohio Plans
When the MCOP is informed by ODM, or its designee, of a member who is changing to a different MCOP, the disenrolling MCOP must share, at a minimum, the current assessment and care plan, inclusive of the waiver service plan, with the enrolling MCOP prior to the new enrollment effective date.

40. Assisting Members in Maintaining Medicaid Eligibility
Beginning January 1, 2015, the MCOP must assist members with maintenance of Medicaid eligibility by providing timely reminders of annual redetermination dates.

41. The MCOP must ensure accurate claims payment to nursing facility (NF) providers by appropriately modifying payment in the event a member has patient liability obligations, lump sum amounts pursuant to 5160-3-39.1, and/or restricted Medicaid coverage periods. In addition, the MCOP must ensure accurate claims payment to home and community based service waiver providers by appropriately modifying payment in the event a member has patient liability obligations and/or restricted Medicaid coverage periods. The MCOP must accept determinations made by County Department of Job and Family Services (CDJFS) for patient liability obligations, lump sum amounts, and restricted Medicaid coverage periods as documentation from the providers submitting claims and adjustments.

42. Patient liability and cost of care reconciliation: Pursuant to Appendix B-5.c.i of the approved 1915(c) MyCare Ohio waiver, following a 4-month claims run-out period, MCOPs must provide monthly reconciliation reports to each AAA documenting any month for which the waiver member's actual cost of LTSS waiver services is less than the member's patient liability amount for the same period. The report must specify the actual payment amount of LTSS waiver services delivered and the patient liability amount for the applicable month.

43. Waiver Enrollment
For new enrollment on the MyCare IC waiver, the MCOP or its designee must assist the member in completing and submitting to the CDJFS form 2399 REQUEST FOR MEDICAID HOME AND COMMUNITY-BASED SERVICES (HCBS) using the "other" box to identify the application for the MyCare Ohio Waiver. This will prompt the CDJFS to open the Waiver screen. The open waiver screen is necessary to allow the Area Agency on Aging ("Waiver Worker") to subsequently enter the level of care (LOC) and IC Waiver Type code into CRIS-E screen Application Entry Individual Waiver (AEIWV). The CDJFS will generate a waiver eligibility approval or denial notice with hearing rights. MCOPs must authorize waiver services in accordance with OAC 5160-58-01.1 and 5160-26-03.1.

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

a. Health Information System

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

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

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

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

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

a. Before the MCOP may submit production files;

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

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

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

operational, that MCOP will have up to ninety (90) days to submit an acceptable test file and an acceptable production file.

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

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

(i) Claims Adjudication

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

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

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

(iii) The MCOP must have policies providing that, upon discovery of claims payment systemic errors that resulted in incorrectly underpaying or denying claims, the MCOP is required to reprocess and correctly pay such claims, from the date of identification of the error retroactively through the period specified in the contract between the MCOP and the provider for claims payment corrective activity. A claims payment systemic error is defined as involving more than five providers, or involving a significant number of payment errors if five or fewer providers are affected. If a claims payment systemic error occurs, the MCOP shall notify ODM of the error and shall specify its process and timeline for

corrective action, unless the MCOP corrects the payments within 60 days from the date of identification of the error. The MCOP's policies must include how corrective action will be taken on behalf of all affected providers, regardless of whether the claims payment systemic error is identified by the MCOP or by any provider. If the error is not a claims payment systemic error, the MCOP shall correct the payments within 60 days from the date of identification of the error.

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

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

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

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

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

ASC X12 834 - Benefit Enrollment and Maintenance.

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

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

(vii) Verification of Compliance with HIPAA

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

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

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

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

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

c. Encounter Data Submission Requirements

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

Acceptance Testing

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

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

Encounter Data File Submission Procedures

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

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

e. IDSS Data Submission and Audit Report Requirements

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

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

f. Information Systems Review

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

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

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

ii. Review the completed ISCA and accompanying documents;

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

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

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

vi. Examine MCOP processes for data transfers;

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

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

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

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

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

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

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

49. Information Required for MCOP Websites

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

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

The MCOP member website must also include, at a minimum, the following information which must be accessible to members and the general public without any log-in restriction: (1) MCOP contact information, including the MCOP's toll-free member services phone number, service hours, and closure dates; (2) a listing of the counties the MCOP serves unless the MCOP serves the entire state in which case the MCOP may indicate it services the entire states; (3) the ODM-approved MCOP member handbook, recent newsletters and announcements; (4) the MCOP's on-line provider directory as referenced in section 42.a. of this Appendix; (5) a list of services requiring prior authorization (PA); (6) the MCOP's preferred drug list (PDL), including an explanation of the list and identification of any preferred drugs

that require PA, the MCOP's list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCOP's policy for coverage of generic versus brand name drugs : (7) the toll-free telephone numbers for the 24/7 medical advice, behavioral health crisis and care management support services call-in systems specified in section 28 of this Appendix; and (8) contact information to schedule non- emergency transportation assistance, including an explanation of the available services and to contact member services for transportation services complaints. The toll-free member services, 24/7 call-in systems and transportation scheduling telephone numbers must be easily identified on either the MCOP's website home page or a page that is direct link from a contact button on the home page. ODM may require the MCOP to include additional information on the member website as needed.

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

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

The MCOP provider website must also include, at a minimum, the following information which must be accessible to providers and the general public without any log-in restrictions: (1) MCOP contact information, including the MCOP's designated contact for provider issues; (2) a listing of the counties the MCOP serves unless the MCOP serves the entire state in which case the MCOP may indicate it services the entire states; (3) the MCOP's provider manual including the MCOP's claims submission process, as well as a list of services requiring PA, recent newsletters and announcements; (4) the MCOP's policies and procedures for out-of-network providers to seek payment of claims for emergency, post-stabilization and any other services authorized by the MCOP; (5) the MCOP's on-line provider directory as referenced in section 42.a. of this appendix; and (6) the MCOP's PDL, including an explanation of the list and identification of any preferred drugs that require PA, the MCOP's list of drugs that require PA, including an explanation of the list, identification of first line drugs for drugs that require PA for step therapy, how to initiate a PA, and the MCOP's policy for coverage of generic versus brand name drugs. ODM may require the MCOP to include additional information on the provider website as needed.

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

Provide all Healthchek information as specified in 27.b.i. of this Appendix.

d. The MCOP must adhere to website requirements set forth in 2.12.5.1.4 and 2.14.3.1.3 of the Three-Way Contract.

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

51. PCP Feedback – The MCOP must have the administrative capacity to offer feedback to individual providers on their: 1) adherence to evidence-based practice guidelines; and 2) positive and negative care variances from standard clinical pathways that may impact outcomes or costs. In addition, the feedback information may be used by the MCOP for activities such as provider performance improvement projects that include incentive programs or the development of quality improvement programs.

52. Coordination of Benefits - When a claim is denied due to third party liability, the MCOP must timely share appropriate and available information regarding the third party to the provider for the purposes of coordination of benefits, including, but not limited to third party liability information received from ODM. In addition, the MCOP must follow the requirements set forth in 5.1.13 of the Three-Way Contract.

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

54. The MCOP must subscribe to the appropriate distribution lists for notification of all 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 MCOP is solely responsible for submitting its names and email addresses to the appropriate distribution lists and is also responsible for ensuring the validity of any e-mail addresses maintained on those distribution lists.

55. Transfer of PHI from ODM Incident Management and Provider Oversight Contractor(s)

ODM contracts with a vendor, Public Consulting Group (PCG), to serve as the incident management vendor for ODM with respect to the management and investigation of incidents and provider oversight for certain Ohio Medicaid waiver consumers.

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

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

Business Associate Agreements directly with ODM in accordance with HIPAA and the Privacy Regulations.

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

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

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

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

58. As outlined in OAC rules 5160-58-01.1 and 5160-26-05 and the Three-Way, MCOP subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).

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

60. The MCOP must hold and maintain, or must be actively seeking and working towards, accreditation by the National Committee for Quality Assurance (NCQA) as specified in 2.2.4 of the Three-Way.

61. Advisory Councils

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This provision shall survive the termination of the Agreement.

64. Assisting Members in Finding Individual Providers

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

APPENDIX D

ODM RESPONSIBILITIES

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

General Provisions

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

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

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

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

5. ODM will provide MCOPs with linkages to organization(s) that can provide guidance on the development of effective strategies to eliminate health disparities.

6. ODM will conduct an annual analysis of Medicaid eligible individuals to identify whether there are any prevalent common primary languages, other than English, in an MCOP's service area. ODM will notify the MCOP of any languages that are identified as prevalent for the purpose of translating marketing and member materials. .

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

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

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

10. Consumer Information

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

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

c. If an MCOP elects not to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, ODM will provide coverage and reimbursement for these services for the MCOP's members. As applicable, ODM will provide information to the MCOP's members on what services the MCOP will not cover and how and where the MCOP's members may obtain these services.

11. Membership Selection and Premium Payment

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

b. Auto-Assignment Eligible individuals that fail to select a plan will be assigned to an MCOP at the discretion of ODM.

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

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

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

f. Remittance Advice (RA) - ODM will confirm all premium payments paid to the MCOP during the month via a monthly RA. ODM or its designated entity will provide a record of each recipient detail level payment via HIPAA 820 compliant transactions. ODM or its designee will keep a record of each MCPs Accounts Payable (e.g. Pay 4 Performance,

Primary Care Rate Increase, and Health Insurance Provider Fee) and Accounts Receivable (e.g. PCRI Reconciliation, Penalty, Credit Balance) transaction on the MITS Provider Portal Report Tab.

g. ODM will provide optional dual benefits enrollment and will not require mandatory Medicaid only enrollment for individuals who are determined eligible for County Board of Developmental Disabilities Services.

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

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

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

APPENDIX E

F. Kevin Russell
Principal

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Confidential
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Ohio Department of Medicaid
Financial Analysis and Rate Setting
Lazarus Building
50 West Town Street, Suite 400
Columbus, OH 43215

April 3, 2014

Subject: MyCare Opt-In and Opt-Out Rates — Calendar Years 2014 and 2015

Dear Ms. Ghatak:

The State of Ohio (State) through the Ohio Department of Medicaid (ODM) has contracted with Mercer Government Human Services Consulting (Mercer) to provide rate and program support on the MyCare program that will be implemented in May 2014 with a regional phase-in over three months, where the phase-in schedule is provided in Table 1.2. The beginning of MyCare implementation for each region through December 31, 2014 will be referred to as calendar year (CY) 2014, or as Partial CY 2014, throughout this document. The MyCare program is a managed care program that will enroll members who have both Medicare and Medicaid eligibility (dual eligibles), into a plan for the provision of Medicaid services. Dual eligibles who elect to receive both Medicare and Medicaid services through the MyCare plan will be members of the MyCare dual-demonstration program. These members will be referred to as Opt-In members, whereas members who receive Medicaid-only services through the MyCare plan, will be referred to as Opt-Out members. In return for providing medical, behavioral health, long term services and supports, and case management services to its enrolled Opt-In members, the plans will receive payment from both Medicare and Medicaid. The capitation rates have been adjusted to account for the additional savings possible through coordination of care and efficiency across both programs. This report describes the process used to develop the CY 2014 and CY 2015 Medicaid components of the rates for Opt-In and Opt-Out members.

NOTE: The terms “rates” and “capitation rates” are referenced throughout the document, including the enclosures. Unless otherwise noted, these are intended to reference the Medicaid portion of the rates.

Implementation Schedule

Since MyCare is a new program, enrollment will be phased in on a geographic basis using the regions established by the State. The following table provides a listing of the seven rating regions, the counties included in each region, and the MyCare implementation date for each region.

Table 1.2 — MyCare Counties by Region and Implementation Schedule

MyCare Region	Counties	Implementation Date
Northeast	Cuyahoga, Geauga, Lake, Lorain, and Medina	May 1, 2014
Northeast Central	Columbiana, Mahoning, and Trumbull	Jun 1, 2014
Northwest	Fulton, Lucas, Ottawa, and Wood	Jun 1, 2014
Southwest	Butler, Clermont, Clinton, Hamilton, and Warren	Jun 1, 2014
Central/Southeast	Delaware, Franklin, Madison, Pickaway, and Union	Jul 1, 2014
East Central	Portage, Stark, Summit, and Wayne	Jul 1, 2014
West Central	Clark, Greene, and Montgomery	Jul 1, 2014

Members will only be able to enroll in MyCare plans based on the implementation schedule for each region as provided in the above table.

Potential Rate Updates (Mid CY 2014 and Prior to 2015)

To help the plans understand the revenue associated with the MyCare program, the Medicaid portion of the rates for CY 2014 and CY 2015 are being released together and several months prior to program implementation. Subsequent to the release of these rates, new information may become available that would materially impact the MyCare rates. The types of changes that could impact the rates include, but are not limited to, the semi-annual updates to the nursing facility (NF) per diem rates that are set by the State and new program changes (for example, any adjustments needed to comply with the legislation that amends the Medicaid regulations to define and describe state plan section 1915(i) home- and community-based services (HCBS) released by CMS on January 16, 2014) that are initiated by the State. Also, if actual 2015 Medicare Part A and Part B deductibles vary significantly from those projected, there may be an impact to the trends used in rate development.

Enclosures

Accompanying this letter are the following enclosures, which primarily pertain to the Medicaid portion of the rate:

1. MyCare Rate Structure.

2. Historical (Base) Data Development.
3. Trended Cost Development.
4. Adjustments to Represent a Managed Care Environment.
5. Member enrollment mix adjustment.
6. Calendar Year 2014 and Calendar Year 2015 Rate Summaries.

Rate Certification

In preparing the CY 2014 and CY 2015 capitation rates for the MyCare program, Mercer has used and relied upon enrollment, eligibility, 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. We have reviewed the data and information for internal consistency and reasonableness, but we 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.

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 actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Although there is no current Actuarial Standard of Practice (ASOP) explicitly related to Medicaid managed care rate setting, there has been work undertaken by the American Academy of Actuaries (development of non-binding guidance in an August 2005 Practice Note) and ongoing work by the Actuarial Standards Board (an Exposure Draft of a specific ASOP for Medicaid managed care capitation rate development and certification). Therefore, in compliance with ASOP #1, in addition to the applicable federal regulations at 42 CFR 438.6(c), in the context of Medicaid managed care, Mercer considers the premium rates "actuarially sound" if, for business in the specific state program and for the specified period covered for which this certification is applicable, 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, taxes, and the cost of capital. This definition is based on the one on pages 8–9 of the August 2005 practice note, *Actuarial Certification of Rates for Medicaid Managed Care Programs* published by the American Academy of Actuaries.

Mercer has developed these rates on behalf of the State in accordance with applicable laws and regulations and in compliance with CMS requirements under 42 CFR 438.6(c). The basis for the

rates began with costs developed prior to the application of the Medicare and Medicaid composite savings percentages established by the State and CMS, informed by estimates from CMS, and its contractors. This certification assures that the Medicaid capitated rates were set consistent with 42 CFR 438.6(c), in combination with a qualification that the Medicare capitation rates were established by CMS and the Medicare and Medicaid composite 1% joint savings percentages established by the State and CMS.

MyCare plans 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 plans for any purpose. Mercer recommends that any plan 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.

Capitation rates developed by Mercer are actuarial projections of future contingent events. Actual costs will differ from these projections. Use of these rates for any purpose beyond that stated may not be appropriate. If you have any questions on any of the above, please feel free to contact Kevin Russell at +1 602 522 6559.

Sincerely,

F. Kevin Russell

F. Kevin Russell, FSA, MAAA
Principal

Copy:
Andrea Armendariz, Mercer
Denise Blank, Mercer
Chris Dunker, Mercer
Chris Fuller, Mercer
Kathy Rodham, Mercer
Dennis Yano, Mercer
Enclosures

Enclosure 1

MyCare Rate Structure

The State considered the potential risk variation of various subpopulations along with the ease of operationalization when it determined the MyCare rate structure. Specifically, the MyCare enrollment rules, the varying levels of need of the members, and the existing Medicaid waivers were used to determine the rate structure described within this section.

Regions

Since the choice of MyCare plans will vary by region and the underlying service utilization varied by region, the MyCare rates will vary by the regions listed in the certification letter.

Community Well Members

The Community Well category represents those dual members who do not meet the Nursing Facility Level of Care (NFLOC) standard (including the transition rules) as described later in this section. Within the Community Well category, capitation rates vary by contracting region and the following age groups: 18–44, 45–64, and 65+.

NFLOC

The NFLOC category represents those dual members that are eligible for, or who are enrolled in, one of the Ohio Medicaid HCBS waiver programs[1], or are a long-term nursing facility (NF) resident with 100 or more consecutive days in a NF[2]. The number of NF days is based on Medicare and Medicaid days and includes leave days, which are days when the NFs are paid for a recipient that was discharged from the NF to the hospital but is expected to return to the NF. Once a Medicaid recipient achieves the 100th NF day (regardless of payor), the member will be assigned to the NFLOC rate cell in the subsequent month and the plan would then be paid the higher rate associated with this population. NF residents that have been in a NF for 100 or more days immediately preceding that member's enrollment in the MyCare program will be classified into the NFLOC rate cell on the first day of enrollment.

For the NFLOC rate cell, there is a single rating category for each contracting region. The rates were developed using data from the following NFLOC population groups: Institutional, Community Waiver 18–44, Community Waiver 45–64, and Community Waiver 65+. Projected enrollment growth (including enrollment trends and the effect of managed care on the mix of membership) for each population group was considered before consolidating the results into the NFLOC rate cell. Using this approach, the NFLOC rates reflect the anticipated mix of NFLOC members achieved through effective managed care activities.

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[1]The HCBS waiver programs include: Assisted Living, Choices, Home Care, PASSPORT, and Transitions II.

[2]Gaps in NF care of 15 days or less per discharge count toward the consecutive day requirement for the NFLOC classification and associated payment. In addition, any days that a member spends in an inpatient hospital setting count towards the one-hundred day requirement.

Transitional Rules

Members who had met the criteria for inclusion in the NFLOC rate cell, but later do not, will be transitioned to the Community Well category. The MyCare plan will continue to receive the NFLOC capitation rate for three full months following the change in categorization. Beginning with the fourth month, the plan will receive the Community Well capitation rate.

For members who are initially in the Community Well category, but later require care in a NF on a long term basis, the member will be assigned to the NFLOC rate cell in the month following the member's 100th NF day.

Opt-In and Opt-Out Members

Members enrolled in both Medicare and Medicaid residing in the MyCare-covered regions will be notified of their choice of plans for the MyCare program. If the member does not select a plan, the member will be passively enrolled into one of the MyCare plans for the Medicaid services. However, members will have the option to enroll in the MyCare plan for Medicare services. For purposes of rate setting, those that enroll in MyCare for both Medicare and Medicaid covered benefits are referred to as the Opt-In members, whereas those members who only receive their Medicaid services through the MyCare plan will be referred to as Opt-Out members. Since there will not be any joint Medicare/Medicaid savings for the Opt-Out members, separate rates have been developed for them.

Enclosure 2

Historical (Base) Data Development

Due to complications with the Medicaid Information Technology System (MITS) implementation, fee-for-service (FFS) data paid after July 2011 is of unknown quality and completeness. Recognizing this data concern, the historical FFS claims data used for rate development will be limited to the claims paid by the State prior to MITS, which includes all payments through July 2011 for the months of service from May 2009 through April 2011. Claims data for the period January through April 2009 were used to determine those individuals who had resided in a NF for more than 100 days and were therefore in the NFLOC rating category as of May 2009. The paid claims were summarized by two 12-month periods (May 1, 2009 to April 30, 2010 and May 1, 2010 to April 30, 2011), seven population groups, categories of service, and the seven MyCare regions. The costs per member per month (PMPM) prior to the application of any adjustment were shared with the plans in December 2012 in the databook[3].

This section of the narrative describes the MyCare-covered populations and benefits and the adjustments that were applied to the base data. The following adjustments were applied, where appropriate, to the data after the release of the databook:

- Third Party Liability (TPL).
- Fraud and abuse.
- Pharmacy rebates.
- Disproportionate Share of Hospital (DSH) Payments.
- Graduate Medical Education (GME) Payments.
- Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) prospective costs.
- Patient liability.
- Historical program changes.
- Completion of additional claims run out.

Covered Populations and Services

The base population includes all "full benefit" Medicare and Medicaid enrollees within the selected MyCare demonstration counties. The following populations will not be eligible to participate in the MyCare program and were excluded from the base data:

- Individuals who are only eligible for Medicare savings program benefits: qualified Medicare beneficiary (QMB), supplemental low income medical beneficiary (SLMB), and QI-1.
- Individuals with intellectual disabilities and other developmental disabilities (IDD) who are served through an IDD 1915(c) HCBS waiver or an intermediate care facility/IDD.
- Individuals enrolled in a Program of All-inclusive Care for the Elderly (PACE).
- Individuals enrolled in both Medicare and Medicaid who have other TPL credible health care coverage.
- Individuals under the age of 18.

[3]Subsequent to the release of the databook, “Transportation” services were consolidated into a single category of service.

- Individuals who are Medicare and Medicaid eligible and are on a delayed Medicaid spend down.

While individuals eligible for Medicare Part C are included in the MyCare program, they are excluded from the base data since Medicare Part A and B claims were not available for these individuals. Without these claims, Mercer was not able to accurately determine which of these individuals had met the 100 day requirement for classification in the Institutional population group and inclusion in the NFLOC rate cell.

The MyCare program includes all acute care services (crossover and non-crossover), long-term care (LTC) services, and most behavioral health services. The only behavioral health services that were excluded were habilitation services and services specific for people with IDD.

TPL

Members with credible third party coverage (coverage in addition to Medicare and Medicaid) were excluded from the base data to the extent that they were identifiable within the data.

Fraud and Abuse

To the extent that fraudulent activities have been identified and recovered by the State, these recovered costs are removed from the base data.

Pharmacy Rebates

For dual eligible members, Medicaid is only responsible for a small number of low-cost prescriptions, primarily for over-the-counter drugs that are not covered by Medicare Part D. Mercer does not expect that the plans will be able to achieve any supplemental rebates associated with this limited pharmacy benefit. As a result, no adjustment was made to the base data to reflect pharmacy rebates.

DSH Payments

The inpatient payments made in the State's claim system, which are the starting point for the rate development, exclude any DSH payments. As a result, the rates are net of these payments and no adjustment was necessary.

GME Payments

The inpatient payments made in the State's claim system, which are the starting point for the rate development, include GME payments that are made to select hospitals. As a result, the rates include these payments within the non-crossover inpatient services.

FQHC/RHC Prospective Costs

For FQHCs and RHCs, the State has increased the payments made to these providers to account for the additional costs associated with their operations. Through these prospective payment additions, FQHCs/RHCs are paid at a higher rate compared to the other providers (for example, primary care physicians). For the purposes of rate development, the average cost per service for FQHCs/RHCs was adjusted to represent payment rates that are comparable with other providers.

Patient Liability

In certain circumstances, Medicaid recipients are expected to contribute funds toward their LTC services. These funds can be applied to both NF and HCBS waiver services. Most facilities/providers, including assisted living facilities, are instructed by the State to collect the patient's liability directly from the recipient. In these cases, the amount paid by Medicaid is then reduced by the patient liability amount. This practice will continue with MyCare, so the amount paid to these facility/providers from MyCare plans will be net of patient liability. For HCBS waiver services provided through the PASSPORT and Choices waivers (which focus on 60+ members), the data/rates are gross of patient liability amounts.

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.

Base Data

Once the two base data years were adjusted to account for each program change, the two years were blended together based on the number of member months (MMs) associated with each population group in the base years.

Historical Case Management Costs

For the MyCare program, case management will be treated as a separate service (distinct from the plan administrative expense). The method used to capture the State's historical costs for case management services was different from medical claims since these case management data are not captured within the State's claims system. The State pays the Ohio Area Agencies on Aging (AAAs) (for Ohio Department of Aging [ODA] waivers[4]) and paid CareStar (for ODM waivers[5]) to provide case management for its waiver recipients.

The state fiscal year (SFY) 2012 (July 1, 2011 through June 30, 2012) cost report information submitted by these entities was used to report the historical case management costs for waiver recipients. These historical costs included an allocation of the general administration expenses that were separately itemized within the submitted cost reports. The cost report information was adjusted to reflect only those services that would be funded through the MyCare program.

[4]Assisted Living, Choices, and PASSPORT waivers.

[5]Home Care and Transitions II waivers.

Enclosure 3

Trended Cost Development

The adjusted base data (described in Enclosure 2) was trended to the contract period. This step was performed separately for the beginning of MyCare implementation for each region through December 31, 2014, which will be referred to as calendar year (CY) 2014 (or partial CY 2014) throughout this document, and CY 2015. The adjustments used to produce the trended costs are described within this section and listed below:

- Prospective program changes.
- Trend.
- Seasonality.

Prospective Program Changes

ODM and Mercer reviewed the program changes that would have a material impact upon the cost, utilization, or demographic structure of the program prior to or during the contract period whose impact was not included within the base data. Based on this review, adjustments were made to account for material prospective program changes. This review and subsequent adjustments included changes that were introduced as part of the MyCare waiver, which includes the elimination of cost caps for ODA waivers and the consolidation of the waivers.

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).

Trend adjustments from the 24-month base period of May 2009 through April 2011 are being made to CY 2014. The seasonality adjustments that are described in the next subsection were used to adjust the rates from CY 2014 to reflect the May 1, 2014 through December 31, 2014 rating period; taking into consideration the implementation date for each MyCare region. This approach was used to ensure that the trend and seasonality adjustments are kept separate from one another. For some categories of service, a portion of the cost changes in concert with changes in the Part A or Part B deductible dollar amounts, which change each calendar year. For some other categories, there is no discernible calendar year impact.

Mercer considered several information sources to develop appropriate trend factors to use for MyCare. Analysis of incurred FFS data is a primary source of information that provides insight into particular trend patterns within the Ohio Medicaid environment. The Medicare Part A and Part B deductibles shown in the table below are used in the estimation of trend for those services whose crossover claims are affected by the deductibles. Other trend sources, such as regional and national economic indicators and indices, provide broad perspectives of industry trends in the United States and in the Midwest region. Specific

resources reviewed include Mercer's Survey of Health Care Trends, the Department of Labor Consumer Price Index data, and the CMS National Health Expenditure projections. Mercer's proprietary information about other state Medicaid programs provides additional information about Medicaid patterns of care and how those affect trends.

For crossover claims, the projected 2015 deductibles affect the trend from the base period. For claims other than crossover claims, the trends to CY 2014 are used for another 12 months to reach CY 2015.

Seasonality (CY 2014 Rates Only)

The CY 2014 rate period is May 2014 through December 2014, taking into consideration the implementation date for each MyCare region, a 6–8 month period. For crossover claims (those claims that are first adjudicated by Medicare and then by Medicaid), changes in the Medicare Part A and Part B deductibles can have a significant effect. The Part A deductible amount and associated copayment amounts (for days 61 and over in a benefit period) change effective each January and are imposed on a benefit period basis rather than a calendar year basis. The Part B deductible is a calendar year deductible, so Medicaid payments are higher each January as compared to the other months of the year. Both the Part A and Part B deductible amounts change effective each January, with the new amounts typically announced the prior October. (The most recent Medicare Trustees Report provides projections for these amounts for several years into the future, but these are subject to revision.)

The Ohio MyCare demonstration has a three-month implementation for passive enrollment in May, June, or July 2014. To accommodate all of these start dates, the seasonality adjustment was calculated based on the July through December 2014 period for all regions.

Trended Member Months

Due to the State's efforts to move more members to the community and the general changes in population mix due to the growing Medicaid program, the trended MMs and projected MMs were updated to reflect the mix of members expected in CY 2014 and CY 2015. This update was determined by evaluating recent eligibility information from the State, which included historical MMs through September 2013.

Enclosure 4

Adjustments to Represent a Managed Care Environment

The trended costs (described in Enclosure 3) were adjusted to reflect the expected costs in a managed care environment. These adjustments are described within this section and are summarized below:

- Selection adjustment to reflect member risk for those who opt out for Medicare services.
- Managed care service level assumptions, including anticipated population group mix achieved through managed care efforts.
- MyCare case management to account for the new program requirements.
- MyCare plan non-medical expense (administration) and underwriting gain.
- Application of integrated care joint savings from Medicare and Medicaid program coordination.
- Sales & Use tax and health insuring corporation (HIC) tax.
- Health insurance provider's fee.

Prior to completing the rates, the regional costs were adjusted to smooth out any unexpected cost variation due to smaller cell sizes associated with the Community Waiver and Community Well populations. The final step with the rate development process was combining the Institutional and Community Waiver (18–44, 45–64, and 65+) population groups into the NFLOC rate cell that reflects the anticipated enrollment mix achievable within a managed care environment.

Selection Adjustment

A selection adjustment is used to reflect the effect that member choice has on the health risk of a population enrolled in a managed care product. The MyCare program is unique in that members have a choice among the contracted MyCare plans, but it does not have any alternatives to the MyCare plans for their Medicaid services. For Medicare services in CY 2014, the MyCare-eligible members can choose to enroll in the MyCare plan, a Medicare Advantage plan, or FFS. Starting in CY 2015, MyCare-eligible members will be passively enrolled into the MyCare, and members can opt out of the MyCare plan for Medicare services. Based on this unique program design, we considered how members would make their decisions regarding Medicare services and ultimately their Opt-In/Opt-Out status. Selection adjustments were made to reflect the anticipated health risks of the Opt-In and Opt-Out programs.

Medicaid Managed Care Savings Assumptions

Managed care savings in the MyCare program are expected to come from two sources:

- Change in the population group mix (Institutional, Community Waiver, and Community Well) under managed care compared to the mix in FFS.
- Changes in medical services costs for more cost-effective utilization of services under managed care.

As individuals' health and functional status are maintained and/or improved, the proportion of the population that is in an institutional setting will gradually decline. Conversely, the proportion of the total population that is assumed to be in community-based settings gradually increases over time as individuals are able to be maintained in community settings through better integration, alignment, and coordination of care. Adjustments were made in the rate development to reflect the increase in members served in the community and changes to medical costs under managed care.

Case Management

For the MyCare program, case management is being treated separately from plan administrative costs. The MyCare program has some specific requirements for case management. The development of this cost component contains two distinct types of case management — (1) plan case management, and (2) seriously and persistently mentally ill (SPMI) health home services. Each member either received an AAA + Plan Case Management value or a Plan Case Management value, depending upon their population group and age (<60 or 60+). For the Community Waiver 45–64 population group, a combination of the case management costs for the 60+ and <60 subpopulations was used and was based on the mix of members in each region.

The SPMI health home value was then added for the assumed proportion of SPMI health home members.

AAA + Plan Management Component — Community Waiver 60+

MyCare plans are required to contract with the AAAs for case management services for the Community Waiver members who are age 60 or older (60+). Accounting for this requirement, the projected AAA costs (adjusted for the appropriate assessment requirements) were used as the starting point for the case management costs for the target population. An additional case management component was then added to account for plan operations related to the coordination of acute care services. The trended AAA case management costs were combined with the acute care case management costs to produce the plan case management component for Community Waiver 60+ members.

Plan Management Component — All Other Population Groups

For Institutional and Community Well members, there has not been any historical case management experience to serve as the starting point for this component of the rates. Rather, this rating component was developed based on a review of the case management service requirements, including the frequency that these services would be performed. This information was then used in combination with regional salary information (trended forward to the contract period) to determine the costs for case management personnel. Additional costs were then incorporated for supervision of case management staff, travel expenses, and other administrative expenses. Since the frequency of services, mix of members across case management levels (intensive, high, medium, low, and monitoring) and the member participation rate is expected to be different for Institutional from Community Well members, the rates for these population groups vary — with higher costs associated with the Institutional population group.

For Community Waiver members who are less than age 60 (<60), case management for waiver services has been provided historically through CareStar, the State's vendor. Since the MyCare plans are not required to contract with the State's vendor, the case management

costs that were developed for the Institutional population group were also used for the Community Waiver <60 members because both populations have the same case management requirements, including the expected mix of members with intensive, high, medium, and low case management levels.

The plan case management component was developed separately for each region.

SPMI Health Home Component

Recipients who are SPMI have the option to enroll in a SPMI health home. The plans will be required to pay the SPMI health homes for their services. Some of the health home costs are already incorporated into the rate in the community psychiatric supportive treatment (CPST) services. To avoid double counting any of the SPMI health home services, the SPMI health home PMPM was reduced by the value of projected CPST costs for the appropriate region and population group. The net SPMI health home value was then incorporated into the plan case management component based on the number of SPMI members in each region and population group, assuming that two-thirds of the SPMI population would voluntarily participate in the health home initiative. The SPMI health home component was developed separately for each region.

The SPMI health home costs (net of CPST) were added to the plan case management costs to produce the case management PMPM cost component.

Administration and Underwriting Gain

The actuarially sound capitation rates developed include provisions for the expected Medicaid managed care administrative expense and underwriting gain components.

Application of Integrated Care Joint Savings

One of the main facets of the dual demonstration programs is the calculation of potential savings resulting from the coordination of services across Medicare and Medicaid and how this coordination will result in more appropriate and efficient service utilization and eliminate incentives to achieve savings in one program that increase costs in the other program. This is reflected in the rates through the application of integrated care joint savings to both the Medicaid and Medicare portions of the Opt-In rates. The Medicare portion of the rate is the Medicare A&B Baseline County Rates that cover the services traditionally provided by Medicare Parts A and B. The integrated care joint savings is not applied to the Medicare Part D portion of the rate or for Opt-Out members.

Sales & Use Tax and Health Insuring Corporation Tax

MyCare plans will be required to remit Sales & Use taxes, as well as a HIC tax on the Medicaid premium revenue (but not the Medicare premium revenue). The HIC tax is 1% of premium revenue; the Sales & Use tax varies by county. The value of these taxes was incorporated into the rates on a percent of premium basis after the application of the adjustments that were previously described within this section.

Health Insurance Providers Fee

One of the components of the Affordable Care Act is the requirement that health insurers pay a Health Insurance Providers Fee (HIPF) starting in 2014. Non-profit insurers with more than 80% of their gross revenues from Medicaid, Medicare, and Children's Health Insurance Program risk contracts are exempt. Long term care insurance is exempt from this fee. Even though the IRS has released guidance regarding the treatment of the HIPF, many questions still remain. Because of this, it is unclear how certain aspects of the MyCare will be treated related to the HIPF. Furthermore, the HIPF will be based on 2014 premiums, will not be known until August 2015, and payment will not be due until September 2015. ODM intends to handle any amounts due to the MyCare plans resulting from costs associated with the HIPF outside of the initial payment of the capitation rates.

Regional and Age Factors

The Community Waiver 18–44, 45–64, and 65+ and Community Well 18–44 and 45–64 population groups can become quite small on a regional basis and therefore produce volatile and unexpected results. To mitigate this, a smoothing technique was applied where regional factors and age factors are used to produce the total medical claims without case management for each region and population group combination. This step occurs prior to the inclusion of the region-specific case management value and the application of the aggregate adjustments (administration and underwriting gain, integrated care joint savings, and taxes).

The Institutional and Community Well 65+ population groups are unaffected by this adjustment.

Combined NFLOC Rating Group

In order to develop the NFLOC projection, the rates that were developed separately for the Institutional, Community Waiver 18–44, Community Waiver 45–64, and Community Waiver 65+ were weighted together using the projected MMs (including the impact of managed care on the population mix).

Enclosure 5

Member Enrollment Mix Adjustment (MEMA)

A national risk adjustment model does not currently exist for populations that use long term support services. As a result, a different approach is required to address potential variations in risk among the participating MyCare plans. A MEMA will enable the State to better match payment to risk by recognizing the relative risk/cost differences of major and objectively identifiable population groups included in each NFLOC rate cell. The selected population groups that will be used for this adjustment are the following population groups: Institutional, Community Waiver 18–44, Community Waiver 45–64, and Community Waiver 65+. The MEMA will provide more revenue to plans that have a greater proportion of high risk/cost individuals (Institutional and Community Waiver 18–44 members) and, conversely, provide less revenue to plans that have a lower proportion of high risk/cost individuals (Community Waiver 45–64 and Community Waiver 65+). Being budget neutral, the MEMA will not increase or decrease the State's total amount of committed capitation revenue. This feature will be incorporated into the rate development process starting in the fourth month of MyCare enrollment in each region based on the following schedule:

MyCare Region	Implementation Date	Initial MEMA Adjustment
Northeast	May 1, 2014	Aug 1, 2014
Northeast Central	Jun 1, 2014	Sep 1, 2014
Northwest	Jun 1, 2014	Sep 1, 2014
Southwest	Jun 1, 2014	Sep 1, 2014
Central/Southeast	Jul 1, 2014	Oct 1, 2014
East Central	Jul 1, 2014	Oct 1, 2014
West Central	Jul 1, 2014	Oct 1, 2014

Updates to the MEMA will be made effective January and July of each year.

Relative cost factors are assigned to each of the population groups that comprise the NFLOC rate cell. These relative cost factors are developed by comparing the population group rate to the NFLOC rate. For example, if Institutional members cost $4,000, and the NFLOC rate is $2,000, the relative cost factor is 2.00 ($4,000/$2,000). This same process is repeated for every population group that comprises the NFLOC. The development of the relative cost factors is region-specific, where the rate for a population group in a region is compared to the NFLOC for that same region.

The State will analyze actual plan member enrollment data at selected points in time and determine the enrollment mix or composition in each plan. Multiplying each plan's member enrollment mix by the respective relative cost factors results in an estimate of each plan's average member risk mix. For example, suppose this step results in the following:

- Plan #1 — member risk plan factor 1.0152, meaning this plan has an initial member mix risk profile that is estimated to have 1.52% higher risk/cost than the baseline measure.

- Plan #2 — member risk plan factor 0.9847, meaning this plan has an initial member mix risk profile that is estimated to have 1.53% lower higher risk/cost than the baseline measure.
- Plan #3 — member risk plan factor 1.0421, meaning this plan has an initial member mix risk profile that is estimated to have 4.21% higher risk/cost than the baseline measure.

The State would then initially adjust the plans' capitation rates by the respective member risk plan factor applicable to each plan. In this example, Plan #1 would get an initial 1.52% increase in their capitation rate and so on for the other plans. To ensure that the member mix adjustments do not increase or decrease the total value of capitation revenue, the State would take a final step to ensure budget neutrality. In this final step, the State would compute the total value of capitation revenue before and after the member mix adjustment. If the member mix adjusted revenue is greater than or less than the pre-mix adjusted revenue, each of the plans' rates are adjusted by a single budget-neutral factor. This final step is illustrated in the following example.

	Plan #1	**Plan #2**	**Plan #3**	**Total**
Membership	50,000	30,000	20,000	100,000
Base NFLOC rate	$1,000.00	$1,000.00	$1,000.00	$1,000.00
Plan member risk factor	1.0152	0.9847	1.0421	1.0114
Initial MEMA-adjusted rate	$1,015.20	$984.70	$1,042.1	$1,011.43
Budget neutral factor	0.9887	0.9887	0.9887	= 1/1.0114
Final plan rate	$1,003.73	$973.57	$1,030.32	$1,000.00

MEMA factors will be determined on a regional basis, where each of the region's NFLOC rates will be adjusted using the enrollment attraction patterns specific to that region.
The use of the MEMA factor may be a temporary feature used for the initial rating periods of the program only until another method for accounting for variations in health risk is introduced or until it is determined that the population in each plan has stabilized to a point where further adjustments for risk/acuity differences are deemed unnecessary.

Enclosure 6

Rate Summaries

In the first demonstration year, which consists of CY 2014 and CY 2015, a 1% quality withhold will be applied to the rates. The following rate summaries display the rates gross and net of this withhold amount. The CY 2014 (partial year) and CY 2015 Opt-In and Opt-Out rates are displayed separately.

MyCare Opt-In Rate Summary

Rating Period: Partial Calendar Year 2014

Rate Group	Region	Medicaid Rate	Quality Withhold	Guaranteed Rate
NFLOC	Central / Southeast	$3,974.19	$39.74	$3,934.45
Community Well 18-44	Central / Southeast	$479.93	$4.80	$475.13
Community Well 45-64	Central / Southeast	$658.88	$6.59	$652.29
Community Well 65+	Central / Southeast	$1,139.75	$11.40	$1,128.35
NFLOC	East Central	$3,521.78	$35.22	$3,486.56
Community Well 18-44	East Central	$335.06	$3.35	$331.71
Community Well 45-64	East Central	$446.16	$4.46	$441.70
Community Well 65+	East Central	$1,243.25	$12.43	$1,230.82
NFLOC	Northeast	$3,822.11	$38.22	$3,783.89
Community Well 18-44	Northeast	$415.52	$4.16	$411.36
Community Well 45-64	Northeast	$559.80	$5.60	$554.20
Community Well 65+	Northeast	$1,122.53	$11.23	$1,111.30
NFLOC	Northeast Central	$3,580.04	$35.80	$3,544.24
Community Well 18-44	Northeast Central	$317.77	$3.18	$314.59
Community Well 45-64	Northeast Central	$429.21	$4.29	$424.92
Community Well 65+	Northeast Central	$940.13	$9.40	$930.73
NFLOC	Northwest	$3,541.94	$35.42	$3,506.52
Community Well 18-44	Northwest	$377.98	$3.78	$374.20
Community Well 45-64	Northwest	$500.22	$5.00	$495.22
Community Well 65+	Northwest	$961.90	$9.62	$952.28
NFLOC	Southwest	$4,100.74	$41.01	$4,059.73
Community Well 18-44	Southwest	$356.93	$3.57	$353.36
Community Well 45-64	Southwest	$479.26	$4.79	$474.47
Community Well 65+	Southwest	$1,573.33	$15.73	$1,557.60
NFLOC	West Central	$3,395.31	$33.95	$3,361.36
Community Well 18-44	West Central	$352.16	$3.52	$348.64
Community Well 45-64	West Central	$477.47	$4.77	$472.70
Community Well 65+	West Central	$1,474.17	$14.74	$1,459.43
NFLOC	MyCare Total	$3,744.04	$37.44	$3,706.60
Community Well 18-44	MyCare Total	$384.42	$3.84	$380.58
Community Well 45-64	MyCare Total	$520.15	$5.20	$514.95
Community Well 65+	MyCare Total	$1,214.43	$12.14	$1,202.29

MyCare Opt-Out Rate Summary

Rating Period: Partial Calendar Year 2014

Rate Group	Region	Medicaid Rate	Quality Withhold	Guaranteed Rate
NFLOC	Central / Southeast	$4,030.35	$40.30	$3,990.05
Community Well 18-44	Central / Southeast	$498.33	$4.98	$493.35
Community Well 45-64	Central / Southeast	$681.21	$6.81	$674.40
Community Well 65+	Central / Southeast	$1,160.77	$11.61	$1,149.16
NFLOC	East Central	$3,572.97	$35.73	$3,537.24
Community Well 18-44	East Central	$351.76	$3.52	$348.24
Community Well 45-64	East Central	$467.22	$4.67	$462.55
Community Well 65+	East Central	$1,265.02	$12.65	$1,252.37
NFLOC	Northeast	$3,876.75	$38.77	$3,837.98
Community Well 18-44	Northeast	$433.72	$4.34	$429.38
Community Well 45-64	Northeast	$582.37	$5.82	$576.55
Community Well 65+	Northeast	$1,144.81	$11.45	$1,133.36
NFLOC	Northeast Central	$3,631.15	$36.31	$3,594.84
Community Well 18-44	Northeast Central	$333.91	$3.34	$330.57
Community Well 45-64	Northeast Central	$449.69	$4.50	$445.19
Community Well 65+	Northeast Central	$962.89	$9.63	$953.26
NFLOC	Northwest	$3,595.35	$35.95	$3,559.40
Community Well 18-44	Northwest	$396.01	$3.96	$392.05
Community Well 45-64	Northwest	$522.98	$5.23	$517.75
Community Well 65+	Northwest	$984.02	$9.84	$974.18
NFLOC	Southwest	$4,156.81	$41.57	$4,115.24
Community Well 18-44	Southwest	$373.57	$3.74	$369.83
Community Well 45-64	Southwest	$500.13	$5.00	$495.13
Community Well 65+	Southwest	$1,599.04	$15.99	$1,583.05
NFLOC	West Central	$3,445.24	$34.45	$3,410.79
Community Well 18-44	West Central	$368.97	$3.69	$365.28
Community Well 45-64	West Central	$498.62	$4.99	$493.63
Community Well 65+	West Central	$1,499.44	$14.99	$1,484.45
NFLOC	MyCare Total	$3,797.58	$37.98	$3,759.60
Community Well 18-44	MyCare Total	$401.82	$4.02	$397.80
Community Well 45-64	MyCare Total	$541.88	$5.42	$536.46
Community Well 65+	MyCare Total	$1,237.24	$12.37	$1,224.87

MyCare Opt-In Rate Summary

Rating Period: Calendar Year 2015

Rate Group	Region	Medicaid Rate	Quality Withhold	Guaranteed Rate
NFLOC	Central / Southeast	$3,996.35	$39.96	$3,956.39
Community Well 18-44	Central / Southeast	$508.51	$5.09	$503.42
Community Well 45-64	Central / Southeast	$693.89	$6.94	$686.95
Community Well 65+	Central / Southeast	$1,176.67	$11.77	$1,164.90
NFLOC	East Central	$3,520.63	$35.21	$3,485.42
Community Well 18-44	East Central	$358.62	$3.59	$355.03
Community Well 45-64	East Central	$475.70	$4.76	$470.94
Community Well 65+	East Central	$1,272.49	$12.72	$1,259.77
NFLOC	Northeast	$3,825.98	$38.26	$3,787.72
Community Well 18-44	Northeast	$442.78	$4.43	$438.35
Community Well 45-64	Northeast	$591.35	$5.91	$585.44
Community Well 65+	Northeast	$1,156.71	$11.57	$1,145.14
NFLOC	Northeast Central	$3,576.74	$35.77	$3,540.97
Community Well 18-44	Northeast Central	$341.52	$3.42	$338.10
Community Well 45-64	Northeast Central	$459.24	$4.59	$454.65
Community Well 65+	Northeast Central	$967.07	$9.67	$957.40
NFLOC	Northwest	$3,534.42	$35.34	$3,499.08
Community Well 18-44	Northwest	$392.79	$3.93	$388.86
Community Well 45-64	Northwest	$521.70	$5.22	$516.48
Community Well 65+	Northwest	$990.52	$9.91	$980.61
NFLOC	Southwest	$4,087.96	$40.88	$4,047.08
Community Well 18-44	Southwest	$378.10	$3.78	$374.32
Community Well 45-64	Southwest	$507.54	$5.08	$502.46
Community Well 65+	Southwest	$1,612.33	$16.12	$1,596.21
NFLOC	West Central	$3,400.35	$34.00	$3,366.35
Community Well 18-44	West Central	$376.66	$3.77	$372.89
Community Well 45-64	West Central	$508.15	$5.08	$503.07
Community Well 65+	West Central	$1,513.11	$15.13	$1,497.98
NFLOC	MyCare Total	$3,745.08	$37.45	$3,707.63
Community Well 18-44	MyCare Total	$408.38	$4.08	$404.30
Community Well 45-64	MyCare Total	$550.26	$5.50	$544.76
Community Well 65+	MyCare Total	$1,248.77	$12.49	$1,236.28

MyCare Opt-Out Rate Summary

Rating Period: Calendar Year 2015

Rate Group	Region	Medicaid Rate	Quality Withhold	Guaranteed Rate
NFLOC	Central / Southeast	$4,055.29	$40.55	$4,014.74
Community Well 18-44	Central / Southeast	$529.16	$5.29	$523.87
Community Well 45-64	Central / Southeast	$718.96	$7.19	$711.77
Community Well 65+	Central / Southeast	$1,199.47	$11.99	$1,187.48
NFLOC	East Central	$3,574.26	$35.74	$3,538.52
Community Well 18-44	East Central	$377.44	$3.77	$373.67
Community Well 45-64	East Central	$499.36	$4.99	$494.37
Community Well 65+	East Central	$1,295.88	$12.96	$1,282.92
NFLOC	Northeast	$3,883.12	$38.83	$3,844.29
Community Well 18-44	Northeast	$463.25	$4.63	$458.62
Community Well 45-64	Northeast	$616.68	$6.17	$610.51
Community Well 65+	Northeast	$1,180.90	$11.81	$1,169.09
NFLOC	Northeast Central	$3,630.17	$36.30	$3,593.87
Community Well 18-44	Northeast Central	$359.81	$3.60	$356.21
Community Well 45-64	Northeast Central	$482.39	$4.82	$477.57
Community Well 65+	Northeast Central	$992.04	$9.92	$982.12
NFLOC	Northwest	$3,590.47	$35.90	$3,554.57
Community Well 18-44	Northwest	$412.97	$4.13	$408.84
Community Well 45-64	Northwest	$547.11	$5.47	$541.64
Community Well 65+	Northwest	$1,014.67	$10.15	$1,004.52
NFLOC	Southwest	$4,146.23	$41.46	$4,104.77
Community Well 18-44	Southwest	$396.85	$3.97	$392.88
Community Well 45-64	Southwest	$531.03	$5.31	$525.72
Community Well 65+	Southwest	$1,639.87	$16.40	$1,623.47
NFLOC	West Central	$3,452.76	$34.53	$3,418.23
Community Well 18-44	West Central	$395.64	$3.96	$391.68
Community Well 45-64	West Central	$531.97	$5.32	$526.65
Community Well 65+	West Central	$1,540.29	$15.40	$1,524.89
NFLOC	MyCare Total	$3,801.09	$38.01	$3,763.08
Community Well 18-44	MyCare Total	$427.97	$4.28	$423.69
Community Well 45-64	MyCare Total	$574.66	$5.75	$568.91
Community Well 65+	MyCare Total	$1,273.45	$12.73	$1,260.72

APPENDIX F

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APPENDIX G
MYCARE
COVERAGE AND SERVICES

1. Basic Benefit Package

After consideration of third party liability including Medicare coverage pursuant to OAC rules 5160-58-01.1 and 5160-26-09.1, a MyCare Ohio Plan (MCOP) must ensure that its members have access to all medically-necessary medical, drug, behavioral health, nursing facility and home and community-based waiver services covered by Medicaid pursuant to OAC rule 5160-58-03(A), with limited exclusions, limitations and clarifications [see OAC rule 5160-58-03(H) and section G.2 of this Appendix]. An MCOP must also ensure that its members have access to any additional services specified in this Agreement. For information on Medicaid-covered services, MCOPs must refer to the Ohio Department of Medicaid (ODM) website.

Services covered by the MCOP benefit package include, but are not limited to the following:

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

practitioner services

- Free-standing birth center services in free-standing birth centers as defined in OAC 5160-18-01

- Prescription drugs

- Ambulance and ambulette services

- Dental services

- Durable medical equipment and medical supplies, including expedited wheelchair fitting, purchase, maintenance and repair, professional evaluation, home assessment, the services of skilled wheelchair technicians, pick-up and delivery, timely repairs, training, demonstration and loaner chairs.
- Vision care services, including eyeglasses

- Nursing facility services

- Hospice care

- Behavioral health services, including the following behavioral health services provided by the Ohio Department of Mental Health and Addiction Services (MHAS)-certified providers:

    - Behavioral Health Assessment
    - Behavioral Health Counseling and Therapy (Individual and Group)
    - Crisis Intervention (24-hour availability)
    - Partial Hospitalization
    - Inpatient psychiatric hospitalization in free-standing and state-operated psychiatric hospitals (see limitations in section G.2.b.iii of this appendix)
    - Community Psychiatric Support Treatment (Individual and Group)
    - Ambulatory Detoxification
    - Targeted Case Management for AOD
    - Intensive Outpatient Programs (IOP)
    - Laboratory Urinalysis
    - Medication/Somatic Treatment Services
    - Methadone Administration

- Immunizations [*An MCOP must follow the coverage requirements provided by ODM for any newly approved vaccine under the Vaccines for Children (VFC) program]

- Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit, as described in OAC rule 5160-4-34

- Telemedicine

- Home and community-based waiver services specified below using providers that are certified by the Ohio Department of Aging (ODA) or approved by ODM and meet the requirements in Chapters 173-39 or 5160-45 of the Administrative Code, as appropriate:
    - Adult Day Health
    - Homemaker
    - Personal Care
    - Alternative Meals Service
    - Assisted Living Service
    - Home Care Attendant Service
    - Chore Services
    - Community Transition Service
    - Emergency Response Services
    - Enhanced Community Living Service
    - Home Care Attendant
    - Home Delivered Meals
    - Home Medical Equipment and Supplemental Adaptive and Assistive Device Services (contingent upon the completion of an evaluation from a licensed health care professional, occupational therapist, physical therapist or other skilled therapist, as appropriate to the service being rendered).
    - Home Modification, Maintenance and Repair (contingent upon the evaluation from a licensed physical therapist or occupational therapist to evaluate the need for home modification, maintenance and repair services for members).
    - Independent Living Assistance
    - Nutritional Consultation
    - Out-of-Home Respite
    - Pest Control
    - Social Work Counseling
    - Waiver Nursing Service
    - Waiver Transportation

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

a. <u>Exclusions</u>

An MCOP is not required to pay for services not covered by the Medicaid program, except as otherwise specified in OAC rule 5160-58-03 and/or this Agreement. Information regarding Medicaid non-covered services can be found on the ODM web site. Services not covered by the Medicaid program include, but are not limited to, the following:

- Services or supplies that are not medically necessary

- Treatment of obesity unless medically necessary
- Experimental services and procedures, including drugs and equipment not covered by Medicaid, and not in accordance with customary standards of practice.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
- Infertility services for males or females
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
- Reversal of voluntary sterilization procedures
- Plastic or cosmetic surgery that is not medically necessary (*These services could be deemed medically necessary if medical complications/conditions in addition to the physical imperfection are present).
- Sexual or marriage counseling
- Acupuncture and biofeedback services
- Services to find cause of death (autopsy) or services related to forensic studies
- Paternity testing
- Services determined by another third-party payor as not medically necessary.
- Drugs not covered by the Ohio Medicaid pharmacy program as specified in OAC 5160-9-03, including drugs for the treatment of obesity.
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual. Assisted suicide services do not include withholding or withdrawing medical treatment, nutrition or hydration or the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death.
- Medical services if the service was caused by a provider-preventable condition as defined in 42 CFR 447.26. The prohibition on payment for provider-preventable conditions shall not result in a loss of access to care or services for Medicaid consumers.
- An MCOP is not required to pay for non-emergency services or supplies provided by non-panel providers, unless the member has followed the instructions in the MCOP

member handbook for seeking coverage of such services, or unless otherwise directed by ODM.

b. Limitations & Clarifications

i. Member Cost-Sharing

As specified in Appendix A, Section 3.3 of the Three-Way, MCOPs may elect to implement co-payments for Medicaid-covered drugs, but will not charge cost sharing to members above levels established under the Medicare Part D Low Income Subsidy. Pursuant to Appendix C, Section 3.3(C) of the Three-Way, members who reside in a nursing facility (NF) or are enrolled in the MyCare 1915(c) waiver may be required to contribute to the cost of care the amount of patient liability established by the County Department of Job and Family Services.

ii. Abortion and Sterilization

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

Additionally, payment must not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion or sterilization itself does not qualify for payment. The MCOP is responsible for educating its providers on the requirements; implementing internal procedures including systems edits to ensure that claims are only paid once the MCOP has determined if the applicable forms are completed and the required criteria are met, as confirmed by the appropriate certification/consent forms; and for maintaining documentation to justify any such claim payments. If the MCOP has made the determination that the requirements associated with an abortion, sterilization, or hysterectomy were sufficiently met by the facility/provider, then no additional information (i.e. operative notes, history and physical, ultrasound etc.) is required from ancillary providers.

iii. Behavioral Health Services Limitations

An MCOP is not responsible for providing mental health services to persons between 22 and 64 years of age while residing in an institution for mental disease (IMD) as defined in Section 1905(i) of the Social Security Act. The MCOP is not prohibited from contracting with an IMD to provide mental health services to persons between 22 and 64 years of age, but the MCOP will not be compensated by Medicaid for the provision of such services (i.e. either through direct payment or considering any associated costs in the Medicaid rate setting process).

iv. Organ Transplants: An MCOP must ensure coverage for organ transplants and related services in accordance with OAC 5160-2-07.1 (B)(4) & and (5). Coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium" based on criteria established by Ohio organ transplant surgeons and authorization from the ODM prior authorization unit. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC 3701-84-01, is contingent upon review and recommendation by the "Ohio Hematopoietic Stem Cell Transplant Consortium" based on criteria established by Ohio experts in the field of bone marrow transplant. While an MCOP may require prior authorization for these transplant services, the approval criteria must be limited to confirming that the consumer is being considered and/or has been recommended for a transplant by either consortium. Additionally, in accordance with OAC 5160-2-03(A)(4) all services related to organ donations are covered for the donor recipient when the consumer is Medicaid eligible.

3. Information Sharing with Non-Panel Providers

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

a. ODM-Designated Providers

In accordance with OAC rules 5160-58-01.1 and 5160-26-03.1, the MCOP must share specific information with FQHCs/RHCs, qualified family planning providers [QFPPs], hospitals and if applicable, certified nurse midwives [CNMs], certified nurse practitioners [CNPs], and free-standing birth centers (FBCs) as defined in OAC 5160-18-01 within the MCOP's service area and in bordering regions if appropriate based on member utilization information. The information must be shared within the first month after the MCOP has been awarded a Medicaid provider agreement for a specific region and annually thereafter. At a minimum, the information must include the following:

- the information's purpose;
- claims submission information including the MCOP's Medicaid provider number for each region (this information is only required to be provided to non-panel FQHCs/RHCs, QFPPs, CNMs, CNPs and hospitals);
- the MCOP's prior authorization and referral procedures;
- a picture of the MCOP's member ID card (front and back); and
- contact numbers for obtaining information for eligibility verification, claims processing, referrals/prior authorization,

post-stabilization care services and if applicable information regarding the MCOP's behavioral health administrator;

- a listing of the MCOP's laboratories and radiology providers.

b. MCOP-authorized Providers

In accordance with OAC rules 5160-58-01.1 and 5160-26-05, an MCOP authorizing the delivery of services from a non-panel provider must ensure that it has a mutually agreed upon compensation amount for the authorized service and must notify the provider of the applicable provisions of OAC rules 5160-58-01.1 and 5160-26-05. This notice is provided when an MCOP authorizes a non-panel provider to furnish services on a one-time or infrequent basis to an MCOP member and must include required ODM-model language and information.

APPENDIX H
MYCARE OHIO
PROVIDER PANEL SPECIFICATIONS

1. FEDERAL ACCESS STANDARDS

A MyCare Ohio Plan (MCOP) must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as assure that it is in compliance with the following federally defined provider panel access standards as required by 42 CFR 438.206:

In establishing and maintaining its provider panel, the MCOP must consider the following:

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

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

In order to comply with 42 CFR 438.206 and 438.207 and demonstrate adequate provider panel capacity and services, the MCOP must submit documentation as specified to the Ohio Department of Medicaid (ODM), in a format specified by ODM, demonstrating that the MCOP offers an appropriate range of preventive, primary care, specialty, behavioral health and waiver services adequate for the anticipated number of members in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area. This documentation of assurance of adequate capacity and services must be submitted to ODM no less frequently than at the time the MCOP enters into a contract with ODM; at any time there is a significant change (as defined by ODM) in the MCOP's operations that would affect adequate capacity and services (including changes in services,

benefits, geographic service or payments); and at any time there is enrollment of a new population in the MCOP.

When a waiver enrollee expresses a preference for an independent (non-agency) provider for an eligible service identified on the member's waiver service plan, the MCOP must seek out an available independent provider. The MCOP must offer the independent provider a contract for provision of the services to the member when the provider is willing, acceptable to the member, and appropriate to the member's care, and approved by ODM/ODA with an active Medicaid provider agreement to render services in accordance with OAC Chapters 173-39 and 5160-45 as appropriate.

2. GENERAL PROVISIONS

MCOP must meet requirements as specified in Section 2.7.9 of the Three-Way and this Appendix including, but not limited to, Section 4 Provider Panel Requirements of this Appendix. The MCOP must remain in compliance with these requirements for the duration of this Provider Agreement.

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

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

In developing the provider panel requirements, ODM considered the population size and the potential availability of the designated provider types. ODM integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODM requires providers to be located anywhere in the region or within a set number of miles from a zip code.

The MCOP must assure that providers submitted to the Managed Care Provider Network (MCPN), or listed in MCOP published directories, are available to both dual benefits and Medicaid only members of the MCOP.

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

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

3. PROVIDER SUBCONTRACTING

Unless otherwise specified in this appendix or OAC rules 5160-58-01.1 and 5160-26-05, an MCOP is required to enter into fully-executed subcontracts with its providers. These subcontracts must include a baseline contractual agreement, as well as the appropriate ODM-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable OAC rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCOP's name.

The MCOP may not employ or contract with providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act. Only those providers who meet the applicable criteria specified in this document, and as determined by ODM, will be counted toward meeting minimum panel requirements. The MCOP must credential and -re-credential providers in accordance with OAC rules 5160-58-01.1 and 5160-26-05. The MCOP must ensure that the provider has met all applicable credentialing criteria before the provider can~~,~~ be listed as a panel provider. At the direction of ODM, the MCOP must submit documentation verifying that all necessary contract documents have been appropriately completed.

The MCPN is a centralized database system that maintains information on the status of MCOP-submitted providers. At a minimum, the MCOP must submit providers associated with the provider types specified in this Appendix, which includes Sections 2.6 and 27 of the Three-Way with the exception of independent providers. The MCOP must notify ODM of the addition and deletion of its contracting providers as specified in OAC rules 5160-58-01.1 and 5160-26-05, and must notify ODM within one working day, in instances where the MCOP has identified that it is not in compliance with the provider panel requirements specified in this appendix. For provider deletions, the MCOP must complete and submit an electronic record terminating the provider from the MCPN or other designated system.

4. PROVIDER PANEL REQUIREMENTS

All MCOPs must provide all medically-necessary Medicaid-covered services to their members. MCOPs must ensure that all network providers follow community standards in the scheduling of routine appointments (i.e., the amount of time members must wait from the time of their request to the first available time when the visit can occur).

The MCOP must comply with all provider network requirements set forth in the Three-Way and the provider network requirements included as part of this Appendix except as explicitly noted herein.

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

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

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

Waiver Providers: The MCOP shall assure that MyCare HCBS waiver providers listed in the charts within Appendix H meet the requirements set forth in OAC Chapters 173-39 and 5160-45, as appropriate, and have an active Medicaid provider agreement with ODM. ODM will not issue a notice of compliance for violation of the minimum standards reflecting in the chart labeled "Waiver Providers" of this Appendix until after July 1, 2015, but MCOPs must assure coverage of these services to their members.

The MCOP must have a written policy setting forth a regular payment cycle for clean claims submitted by independent providers. The MCOP must adhere to the policy and any communications from the MCOP to a provider must be consistent with the policy.

Nursing Facilities: The MCOP must contract with at least the minimum number of facilities that are identified in the attached Appendix H chart.

Behavioral Health Providers: MCOPs must evaluate each region's network capacity of Behavioral Health services (both Medicare and Medicaid). MCOP must perform an assessment of no less than its contracted Medicare providers in each region and county regarding providers' willingness and preparedness to become Medicaid providers of the ODMAS services. The MCOP must also assess whether each region and county's CMHC's area currently certified for Medicare or are prepared and willing to pursue certification for Medicare services. MCOP's must report the results to ODM upon request.

Alcohol and Drug Providers: The MCOP must contract with at least the minimum number of certified Ohio Department of Mental Health and Addiction Services providers identified on the Appendix H charts. In addition, MCOP must ensure there exist adequate provider panel capacity to provide its members with reasonable and timely access to the following services; alcohol/drug screening analysis/lab urinalysis, ambulatory detoxification, assessment, case management, crisis intervention, individual counseling, group counseling, induction of buprenorphine, injection of naltrexone (to treat addiction), intensive outpatient (to treat addiction) and medical somatic services. ODM will not issue compliance for violation of the minimum standards reflected in the chart until after July 1, 2015, but MCOPs must assure coverage of these services to their members.

Mental Health Provider: MCOPs must contract with at least the minimum number of certified Ohio Department of Mental Health and Addiction Services providers identified on the Appendix H charts. In addition, MCOP must assure there exist adequate provider panel capacity to provide its members with reasonable and timely access to the following services within the region, if available; Community Psychiatric Supportive Treatment, Crisis Intervention, Health Home Comprehensive Care Coordination, individual counseling, group counseling, injections (long-acting antipsychotic medications), mental health assessment, partial hospitalization, pharmacological management, psychiatric diagnostic interview and psychological testing. ODM will not issue compliance for violation of the minimum standards reflecting in the chart until after July 1, 2015, but MCOPs must assure coverage of these services to their members.

5. PROVIDER DIRECTORIES

An MCOP's provider directory must include all MCPN-contracted providers as well as certain non-contracted providers as specified by ODM with the exception of independent providers and those providers operating under single case agreements. At the time of ODM's review, the information listed in the MCOP's provider directory for all ODM-required provider types specified on the attached charts must exactly match the data currently on file in the ODM MCPN, or other designated process.

The MCOP's provider directory must utilize a format specified by ODM. The directory may be region-specific or include multiple regions; however, the providers within the directory must be divided by region, county, and provider type, in that order.

The directory must also specify:

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

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

Printed Provider Directory

Prior to executing a provider agreement with ODM, the MCOP must develop a printed provider directory that complies with requirements set forth in Section 2.12.5.2 of the Three-Way and is prior-approved by ODM. Once approved, this directory may be regularly updated with provider additions or deletions by the MCOP without ODM prior-approval; however, a copy of the revised directory (or inserts) must be submitted to ODM prior to distribution to members.

On a quarterly basis, the MCOP **must** create an insert to each printed directory that lists those providers **deleted** from the MCOP's provider panel during the previous three months. 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

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

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

WAIVER PROVIDERS

Mycare Region	Chore Services	Community Transition	Emergency Response	Home Care Attendant-Nursing	Home Medical Equipment & Supplies	Home Modifications	Homemaker	Independent Living Assistance	Meals Home Delivered	Nutritional Counseling	Out of Home Respite	Social Work Counseling	Waiver Transportation	Waiver Nursing Agency	Personal Care- Agency
Central	1	5	19	182	19	8	56	2	16	8	1	20	2	66	182
East Central	2	7	10	72	10	15	24	2	9	5	1	22	6	22	136
Northeast	1	7	16	138	6	6	34	0	13	2	2	31	8	28	145
Northeast Central	2	8	5	32	4	2	10	5	5	3	1	8	2	10	56
Northwest	1	1	3	39	3	2	4	2	10	2	2	12	2	20	57
Southwest	1	8	10	108	6	7	16	2	19	11	1	32	4	26	127
West Central	6	4	4	77	7	8	6	0	8	10	1	12	5	28	88

Nursing Facility-MyCare Provider Panel Analysis

MyCare Region	County	# NF
Central	Delaware	3
Central	Franklin	16
Central	Madison	1
Central	Pickaway	2
Central	Union	1
East Central	Portage	2
East Central	Stark	11
East Central	Summit	14
East Central	Wayne	5
Northeast	Cuyahoga	31
Northeast	Geauga	2
Northeast	Lake	4
Northeast	Lorain	4
Northeast	Medina	4
Northeast Central	Columbiana	5
Northeast Central	Mahoning	7
Northeast Central	Trumbull	7
Northwest	Fulton	2
Northwest	Lucas	12
Northwest	Ottawa	2
Northwest	Wood	4

MyCare Region	County	# NF
Southwest	Butler	7
Southwest	Clermont	4
Southwest	Clinton	1
Southwest	Hamilton	23
Southwest	Warren	6
West Central	Clark	4
West Central	Greene	3
West Central	Montgomery	12
	Grand Total	**199**

MyCare Region	OHMAS Mental Health Providers	OHMAS Alcohol & Drug Providers
Central	18	8
East Central	19	8
Northeast	50	8
Northeast Central	10	6
Northwest	10	6
Southwest	28	8
West Central	19	6

Northeast

	Vision	Dental
Cuyahoga	32	85
Geauga	0	1
Lake	2	7
Lorain	3	13
Medina	1	4
Total	**38**	**110**

Northeast Central

Columbia	0	2
Mahoning	5	11
Trumbull	4	8
Total	**9**	**21**

Northwest

Fulton	0	2
Lucas	9	26
Ottawa	0	1
Wood	2	2
Total	**11**	**31**

Southwest

Butler	4	13
Clermont	1	5
Clinton	1	1
Hamilton	14	34
Highland	2	3
Total	**22**	**56**

West Central

Clark	3	6
Greene	3	3
Montgomery	13	23
Total	**19**	**32**

East Central

	Vision	Dental
Portage	0	3
Stark	7	17
Summit	11	23
Wayne	0	3
Total	18	46

Central

Delaware	3	3
Franklin	20	60
Madison	0	1
Pickaway	1	1
Union	1	1
Total	25	66

APPENDIX I

PROGRAM INTEGRITY

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

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

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

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

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

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

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

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

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

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

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

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

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

i. Embezzlement and theft – MCOPs 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 – MCOPs 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 MCOP must immediately investigate and, if indicated, correct the problem(s) which resulted in such underutilization of services.

The MCOP'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 MCOP'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 MCOP service denials and utilization in order to identify services which may be underutilized.

iii. Claims submission and billing – On an ongoing basis, MCOPs 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 MCOP fraud and abuse activities: Pursuant to OAC rule 5160-26-06, MCOPs are required to submit annually to ODM a report which summarizes the MCOP's fraud and abuse activities for the previous year in each of the areas specified above. The MCOP's report must also identify any proposed changes to the MCOP's compliance plan for the coming year.

d. Member fraud: MCOPs 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: MCOPs are required to promptly report all instances of provider fraud and abuse to ODM and member fraud to the CDJFS. The MCOP, at a minimum, must report the following information on cases where the MCOP'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 MCOP;

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 MCOP's investigation and actions taken;

vii. Name(s) of other agencies/entities (e.g., medical board, law enforcement) notified by MCOP; 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 MCOP's policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the MCOP will not knowingly have a relationship with individuals debarred by Federal Agencies, as specified in Article XII of the Agreement.

g. The MCOP 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 MCOP must submit within 35 days of the date requested by ODM or HHS full and complete information about:
   i. the ownership of any subcontractor with whom the MCOP has had business transactions totaling more than $25, 000 during the 12-month period ending on the date of the request.

ii. any significant business transactions between the MCOP and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

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

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

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

k. Non-federally qualified MCOPs 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, MCOPs are required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to ODM which may affect MCOP payment.

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

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

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

      iii. Cost Reports [as specified in the Fiscal Performance Appendix (Appendix J)]

      iv. Care Management Data [as specified in the Data Quality Appendix (Appendix L)]

      v. HEDIS IDSS Data/FAR [as specified in the Data Quality Appendix (Appendix L)]

      vi. CAHPS Data [as specified in the Data Quality Appendix (Appendix L)]

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

i. The MCOP's Chief Executive Officer;

ii. The MCOP's Chief Financial Officer,

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

MCOPs must provide certification as to the accuracy, completeness, and truthfulness of additional submissions.

3. Pursuant to 42 CFR 455.20, MCOPs must have a method for verifying with enrollees whether services billed by providers were received. Therefore, the MCOP is required to conduct a mailing of Explanation of Benefits (EOBs) to a 95% confidence level (plus or minus 5 percent margin of error) sample of the MCOP's enrollees once a year. The EOB mailing must only include those members that have received health care services within the last six months, comply with all state and federal regulations regarding release of personal health information, outline the recent medical services identified as having been provided to the enrollee, and request that the enrollee report any discrepancies to the MCOP. MCOPs 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: MCOPs must report the number of breaches of protected health information (PHI) and specify how many breaches were reported to HHS as required by 45 CFR Part 164.408 (b) and (c). This report must be submitted annually as indicated on the "MCOP Calendar of Required Submissions."

5. **Credible Allegation of Fraud**: MCOPs must promptly refer suspected cases of fraud to ODM for investigations and determination of whether a credible allegation of fraud exists. 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

FOR MYCARE OHIO PLANS

Pursuant to Section 2.13, Financial Requirements, of the Three-Way Contract, MyCare Ohio Plans (MCOPs) must adhere to the financial measures, standards and reporting requirements contained therein. In addition, MCOPs must adhere to the prompt pay standards set forth in Section 5.1.9.1 of the Three-Way Contract.

APPENDIX K

QUALITY CARE

This Appendix establishes program requirements and expectations related to the MyCare Ohio Plan's (MCOP's) responsibilities for developing and implementing a care delivery model, which include the establishment of a primary care provider for individuals; health promotion and wellness activities; a care management program; and utilization management programs. The MCOP must also develop Quality Assessment and Performance Improvement programs and participate in external quality review activities. These program requirements are applicable to dual benefits (also referred to as "opt in") members and Medicaid only (also referred to as "opt out) members and support the priorities and goals set forth in the Ohio Medicaid Quality Strategy.

1. Care Delivery Model

   a. Primary Care: In accordance with the Three-Way Contract between MCOP, CMS and ODM (the Three-Way), Section 2.5.1, the MCOP is required to ensure that each Medicaid only member has a primary care provider who will serve as an ongoing source of primary and preventive care and will perform care coordination activities appropriate to the member's needs.

   b. Health Promotion and Wellness Activities: In accordance with the Three-Way, Section 2.5.2, each MCOP must develop and offer a range of health and wellness programs and informational material that target specific health needs and risk behaviors identified for the MCOP's membership.

   c. Direct access to specialists: In accordance with the Three-Way, Section 2.6.1.16, the MCOP must implement a provision for members, specifically those with special health care needs, to directly access a specialist (e.g., for an approved number of visits or a standing referral) as appropriate for the member's condition and health care needs. The MCP must inform members of their right to directly access a specialist.

   d. Utilization Management Programs: In accordance with the Three-Way, Sections 2.4 and 2.8, and Ohio Administrative Code (OAC) 5160-58-01.1 and 5160-26-03.1(A)(7), the MCOP must implement utilization management programs with clearly defined structures and processes to maximize the effectiveness of the care provided to dual benefits and Medicaid only members.

      i. Drug Utilization Management Programs: The MCOP may, pursuant to ORC Sec. 5167.12 implement strategies for the management of drug utilization for Medicaid covered drugs that are not covered by Medicare Part D. The MCP may, subject to ODM prior approval, require prior authorization of certain drug classes and place limitations on the type of provide and locations where certain drugs may be administered. MCPs must establish their PA system so that it does

not necessary impede member access to medically-necessary Medicaid covered services. MCOPs must comply with the provisions of OAC 5160-58-01.1 regarding the timeframes for prior authorization of covered outpatient drugs.

ii. For Medicaid covered nursing facility stays, the MCOP must evaluate the member's need for the level of services provided by a nursing facility. To make this decision, the MCOP must use the criteria for nursing facility-based level of care pursuant to OAC rules 5160-3-08 and 5160-1-01.

iii. Nursing Facility Level of Care Determinations - Pursuant to Section 2.5.3.3.5.2 of the Three-Way, MCOPs must request Level of Care determinations for from the local Area Agencies on Aging except in the case of nursing facility stays for which level of care authority is delegated to the MCOP.

e. The MCOP must utilize ongoing medication reconciliation, employment of advanced practice pharmacy management programs, including medication therapy management, and in-person pharmacy consultation to increase adherence to medication regimens and eliminate contra-indicated drugs.

f. Transitions of Care

The MCOP must effectively and comprehensively manage transitions of care between settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The MCOP must at a minimum:

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 MCOP staff who will regularly communicate with the discharging facility and inform the facility of the designated MCOP contacts;
d. ensure that timely notification and receipt of admission dates, discharge dates and clinical information is communicated between internal MCOP departments and between care settings, as appropriate;
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 MCOP;
f. obtain a copy of the discharge/transition plan;
g. arrange for services specified in the discharge/transition plan;
h. conduct timely follow up with the member and member's providers to ensure post discharge services have been provided.

When an MCOP is contacted by an inpatient facility for an MCOP'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 MCOP must initiate and implement steps 2.g.i.c – h, as applicable, to ensure adequate discharge planning occurs for the member.

The MCOP must ensure that the transition/discharge plan and post-discharge services are integrated into the member's care plan.

Upon request, the MCOP may be required to submit the transition of care strategy as prescribed by ODM for approval.

g. Care Management:

i. Care Management Program Requirements: Pursuant to the Three Way, Section 2.5.3, the MCOP must provide care management services to all members, including dual benefits and Medicaid only. In addition, the MCOP must also adhere to the following requirements:

a. For Medicaid only members, the MCOP shall coordinate with any *Medicare Advantage* Plan that is the primary payor of Medicare services, if applicable, in an effort to reduce gaps or duplication of services.

b. The MCOP must also adhere to all operational standards articulated in the approved Ohio Home and Community Based Services 1915(c) waiver for MyCare Ohio.

c. The MCOP is not required to conduct a new initial comprehensive assessment or annual reassessment if an assessment/reassessment was previously conducted by the current/prior MCOP and one of the following conditions apply:

a. A member transitions from Medicaid only to dual benefits status and remains enrolled with the MCOP; or
b. A member was previously enrolled with the current MCOP in the prior 90 calendar days; or
c. A member had an assessment completed with a prior MCOP and the assessment was transferred from the disenrolling MCOP to the enrolling MCOP per Appendix C.

Updates to the initial assessment must comply with Section 2.5.3.2.3.7 of the Three-Way agreement.

d. Sanctions for non-compliance with care management and waiver procedural requirements are identified in Appendix N of this Provider Agreement.

ii. Care Management Staffing ratio: ODM will assess MCOP compliance with the staffing ratios established in the Three Way, Section 2.5.3.3.1.3, and as specified in the *ODM Methods for the My Care Ohio Care Management Staffing Ratio.* The staffing ratio is defined as one full time equivalent (FTE) per the number of dual benefits and Medicaid only members

specified for each risk stratification level below. The staffing ratios must fall within the performance standard ranges for each risk stratification level as specified below:

Risk Stratification Level	Staffing Ratio	Performance Standard
Intensive	1:25 – 1:50	≥.0200
High	1:51 – 1:75	.0196 - .0133
Medium	1:76 – 1:100	.0132 - .0100
Low	1:101 – 1:250	.0099 - .0040
Monitoring	1:251 – 1:350	.00398 and 0029

The staffing ratios will be calculated semiannually for the following measurement periods: July 2014 – December 2014; January 2015 – June 2015; July 2015 – December 2015; January 2016 – June 2016; July 2016 – December 2016; January 2017 – June 2017; and July 2017 – December 2017.

The sanctions for non-compliance with the minimum performance standards are listed in Appendix N of this Provider Agreement.

iii. Comprehensive assessment measures: The MCOP must complete an initial comprehensive assessment and an annual reassessment of medical, behavioral, LTSS and social needs for each MyCare beneficiary as specified in Section 2.5.3.2.3 of the Three Way Agreement. ODM will assess MCOP compliance with these requirements by using results from the following measures:

i. Initial comprehensive assessment:
    1. *Measure*: The percent of members enrolled in the MCOP who received an initial comprehensive assessment within 90 days of the enrollment effective date.
    2. *Measurement periods*: January – March 2015; April – June 2015; July – September 2015; and October – December 2015.
    3. *Minimum Performance Standard*: Less than 10 percentage points below the percentage achieved by the highest performing MCOP during the measurement period.

ii. Annual reassessment:
    1. *Measure*: The percent of members enrolled in the MCOP who received an annual reassessment within 365 days of the initial comprehensive assessment completion date.
    2. *Measurement periods*: July – September 2015; and October – December 2015.
    3. *Minimum Performance Standard*: Less than 10 percentage points below the percentage achieved by the highest performing MCOP during the measurement period.

The sanctions for non-compliance with the minimum performance standards are listed in Appendix N of this Provider Agreement.

iv. Measures and measurement periods and compliance determination
ODM reserves the right to revise the measures and measurement periods established in this Appendix (and their corresponding periods), as needed due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCOP's performance level for that contract period.

In the event an MCOP's performance cannot be evaluated for a care management program evaluation measure and measurement period established in this appendix, ODM in its sole discretion will deem the MCOP to have met or to have not the standard(s) for that particular measure and measurement period depending on the circumstances involved.

v. Care management data submission: The MCOP must submit care management data in accordance with the *My Care Ohio Care Management Data Submission Specifications.*

In accordance with 42 CFR 438.600—438.606, each MCOP must submit the ODM required signed data certification letter to ODM attesting to the accuracy and completeness of care management data submitted to ODM.

Care management data files and the data certification letters are due on the 10th calendar day of each month.

The sanctions for non-compliance with this requirement are listed in the Appendix N of this Provider Agreement.

vi. HCBS Waiver operational reporting requirements:

a. The MCOP must report the following to ODM on the 15th of July, October, January and April of each calendar year:
    i. Total number of individuals who have a risk agreement by the following categories: drug/alcohol issues, unsafe smoking, and non-compliance with healthcare
    ii. Total number of individuals with behavior support plans by category: mechanical restraints, chemical restraints, physical, seclusion, and restrictive interventions
    iii. Total number of behavior support plans by category as indicated in f.iv.a.ii by authorizing entity: physician, psychologist, county board of developmental disabilities, and other behavioral health professional.

iv. Total number of individuals with behavior support plans reported in f.iv.a.ii for which the MCOP activated the behavioral support plan with an indication of the used restraint or seclusion.

v. Total number of individuals with behavior support plans reported in f.iv.a.ii for which the MCOP activated the behavioral support plan with an indication of the restrictive intervention used.

b. In the event that the MCOP activates the Emergency Response Plan pursuant to the Three-Way, Section 2.5.3.3.5.4.6, the MCOP must document the outcomes of the ERP and submit to ODM when requested.

Sanctions for non-compliance with these requirements are listed in Appendix N of this Provider Agreement.

2. Quality Assessment and Performance Improvement Program

a. Each MCOP must implement a Quality Assessment and Performance Improvement program in accordance with the Three-Way, Sections 2.11 that applies to both the dual benefits and Medicaid only populations.

b. Each MCOP must develop and implement Performance Improvement Projects pursuant to the Three-Way, Section 2.11.3.4. Topics will be selected by ODM. The MCOP must adhere to ODM PIP format, content specifications and timelines for PIP implementation and reporting. All PIP submissions will be reviewed and approved by ODM and CMS. The MCOP must submit on an annual basis to ODM the results of each PIP; however, ODM reserves the right to require that MCOPs provide status updates no more frequent than monthly to ODM. The EQRO will assist MCOPs with the development and implementation of PIPs by providing technical assistance and will annually validate the PIPs.

Initiation of PIPs will begin in the 4th quarter of 2014.
No more than two (2) Performance Improvement Projects will be in an active status per calendar year.

The MCOP shall actively participate in performance improvement projects that are facilitated by ODM or the EQRO, or both. This includes but is not limited to:

- Attending meetings;
- Assigning MCOP staff to the PIP efforts who are subject matter experts in the PIP topic, are familiar with MCOP policies and processes related to the topic, have been trained in quality improvement science and rapid cycle quality improvement approaches. and who have decision making authority;
- Responding promptly to data requests;
- Dedicating resources to implement quality improvement interventions;
- Establishing internal mechanisms to frequently communicate PIP status updates and results to the MCOP's Medical Director or Quality Improvement Director; and

- Maintaining regular communication with ODM or EQRO staff.

The MCOP shall integrate results from performance improvement projects into its overall quality assessment and performance improvement program.

MCOP Medical Directors, Quality Improvement Directors, and at least one MCOP staff 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 MCOP 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 the start date unless they have evidence of course completion within the two years prior to their effective start date.

c. Quality Measurement Assessment and Improvement Strategy

The MCOP must measure, analyze, and track performance indicators which reflect Ohio Medicaid's Quality Strategy clinical focus areas (e.g., behavioral health) and other quality initiatives in place to advance the goals of the Quality Strategy. The MCOP must include all measures listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement* Periods and may also include other measures (e.g., the full NCQA accreditation set) that assist the MCOP in advancing the goals of the Quality Strategy and the Duals Demonstration Project.

The MCOP's quality measurement assessment and improvement strategy must include the following activities:

i. Establishing a measureable goal and benchmark for each performance indicator;
ii. Measuring performance and comparing the rate for each indicator to the established goal and benchmark;
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 MCOP must ensure that these activities support the MCOP's quality program. Upon request, the MCOP must make the performance indicator tracking and reporting mechanisms and any quality improvement work plans available for review by ODM.

3. External Quality Review

The MCOP must participate in annual external quality review activities as specified in OAC 5160-58-01.1 and 5160-26-07.

The review will include but not be limited to the following activities:

3.a. Administrative compliance assessment as required by 42 CFR 438.358 and as specified by ODM.

3.a.i. Non duplication exemption – As allowed by 42 CFR 438.360 and 438.362, an MCOP with accreditation from a national organization approved by the Centers for Medicare and Medicaid services may request to be exempted from certain portions of the administrative compliance assessment. ODM will inform the MCOP when a non-duplication exemption may be requested.

3.a.ii. The EQRO may conduct focused reviews of MCOP performance in the following domains which include, but are not limited to:

1. Availability of services
2. Assurance of adequate capacity and services
3. Coordination and continuity of care
4. Coverage and authorization of services
5. Credentialing and 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

3.b. Encounter data studies
3.c. Validation of performance measurement data
3.d. Review of information systems
3.e. Validation of performance improvement projects
3.f. Member satisfaction and/or quality of life surveys

The sanctions for non-compliance with external quality review activities are listed in the Appendix N of this Provider Agreement.

APPENDIX L

DATA QUALITY

A high level of performance on the data quality standards and requirements established in this appendix is crucial in order for the Ohio Department of Medicaid (ODM) to determine the value of the MyCare Ohio Program and to evaluate MyCare Ohio members' access to and quality of services. Encounter data collected from MyCare Ohio Plans (MCOPs) are used in key performance assessments, such as: the external quality review, clinical performance measures, utilization review, care coordination and care management, and in determining quality withholds. The data will also be used in conjunction with the cost reports in setting the capitation rates. The Encounter Data Volume measures, as specified in this appendix, will be calculated separately per MCOP for the dual benefit members (opt-in population) and those Medicaid-only members (opt-out population) and include all MyCare Ohio members receiving services from the MCOP per these two populations. These measures will be calculated separately for Medicaid and Medicare services for the dual benefit members (opt-in population) and only for the Medicaid services for the Medicaid-only members (opt-out population). All other encounter data quality measures, as specified in this Appendix, will be calculated for each MCOP: Rejected Encounters, Acceptance Rate, Encounter Data Accuracy Study measure (Payment Accuracy), Incomplete Rendering Provider Data, NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers, and Timeliness of Encounter Data Submission.

ODM reserves the right to revise the measures and report periods established in this appendix (and their corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCOP's performance level for that contract period.

1. ENCOUNTER DATA

For detailed descriptions of the encounter data quality measures below, see *ODM Methods for the MyCare Ohio Encounter Data Quality Measures*.

1.a. Encounter Data

Each MCOP's encounter data submissions will be assessed for completeness and accuracy per Section 2 of the Three-Way Contract between MCOP, Centers for Medicare and Medicaid Services (CMS) and ODM (Three-Way),. The MCOP is responsible for collecting information from providers and reporting the data to ODM in accordance with program requirements established in Appendix C, *MCOP Responsibilities*. Failure to do so jeopardizes the MCOP's ability to demonstrate compliance with other performance standards.

1.a.i. Encounter Data Volume

Measure: The volume measure for each service category, as listed in the tables below, is the rate of utilization (e.g., discharges, visits) per 1,000 member months (MM).

Report Period: The report periods for Calendar Year (CY) 2014 through CY 2017 contract periods are listed in Table 1 below. Fee-For-Service (FFS) Medicaid data will be used as a baseline to set interim data quality standards for Medicaid services for CY 2014 and the first two quarters of CY 2015. Data quality standards for Medicare services and updated data quality standards for Medicaid services will be determined after ODM has collected Medicaid and Medicare encounter data from the MCOPs for at least two quarters.

Table 1. Report Periods for the CY 2014 - CY 2017 Contract Periods

MCOP Quarterly Report Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1 2014-NA	April 2015	May 2015	CY 2014
Qtr 2: 2014	April 2015	May 2015	
Qtr 2 and Qtr 3: 2014	April 2015	May 2015	
Qtr 3 thru Qtr 4:2014	April 2015	May 2015	
Qtr 2 thru Qtr 4: 2014 Qtr 1 2015	July 2015	August 2015	CY 2015
Qtr 2 thru Qtr 4: 2014 Qtr 1, Qtr 2: 2015	October 2015	November 2015	
Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 3: 2015	January 2016	February 2016	
Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 4: 2015	April 2016	May 2016	

Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 4: 2015 Qtr 1 2016	July 2016	August 2016	CY 2016
Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 4: 2015 Qtr 1, Qtr 2: 2016	October 2016	November 2016	
Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 4: 2015 Qtr 1 thru Qtr 3: 2016	January 2017	February 2017	
Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 4: 2015 Qtr 1 thru Qtr 4: 2016	April 2017	May 2017	

Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 4: 2015 Qtr 1 thru Qtr 4: 2016 Qtr 1 2017	July 2017	August 2017	CY 2017
Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 4: 2015 Qtr 1 thru Qtr 4: 2016 Qtr 1, Qtr 2: 2017	October 2017	November 2017	
Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 4: 2015 Qtr 1 thru Qtr 4: 2016 Qtr 1 thru Qtr 3: 2017	January 2018	February 2018	
Qtr 2 thru Qtr 4: 2014 Qtr 1 thru Qtr 4: 2015 Qtr 1 thru Qtr 4: 2016 Qtr 1 thru Qtr 4: 2017	April 2018	May 2018	

Qtr1 = January to March; Qtr2 = April to June; Qtr3 = July to September; Qtr 4 = October to December

The dual benefit member (opt-in population) data quality standards for the encounter data volume measure for Medicaid and Medicare services are listed in Tables 2. and 3. below. The utilization rate for each service category listed in Tables 2. and 3. must be equal to or greater than the associated standard established for each service category in Tables 2 and 3.

Table 2. Dual Benefit Members (Opt-In Population) Medicaid Services Standards – Encounter Data Volume

Category	Measure per 1,000/MM	Standard	Description
Inpatient Hospital	Discharges	TBD	General/acute care, excluding newborns and mental health and chemical dependency services
Nursing Facility	Claims	TBD	Nursing facility monthly claims
Emergency Department	Visits	TBD	Includes physician and hospital emergency department encounters
Dental		TBD	Non-institutional and hospital dental visits
Vision		TBD	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		TBD	Physician/practitioner and hospital outpatient visits
Behavioral Health	Service	TBD	Inpatient and outpatient behavioral encounters
Waiver		TBD	Professional Waiver services
Pharmacy	Prescriptions	TBD	Prescribed drugs

Table 3. Dual Benefit Members (Opt-In Population) Medicare Services Standards – Encounter Data Volume

Category	Measure per 1,000/MM	Standard	Description
Inpatient Hospital	Discharges	TBD	General/acute care, excluding newborns and mental health and chemical dependency services
Nursing Facility	Claims	TBD	Nursing facility monthly claims
Emergency Department	Visits	TBD	Includes physician and hospital emergency department encounters
Primary and Specialist Care		TBD	Physician/practitioner and hospital outpatient visits
Behavioral Health	Service	TBD	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	TBD	Prescribed drugs

The Medicaid-only member (opt-out population) data quality standards for the encounter data volume measure for Medicaid services are listed in Table 4. below. The utilization rate for each service category listed in Table 44 must be equal to or greater than the associated standard established for each service category in Table 4.

Table 4. Medicaid-only (Opt-Out Population) Medicaid Service Standards – Encounter Data Volume

Category	Measure per 1,000/MM	Standard	Description
Inpatient Hospital	Discharges	TBD	General/acute care, excluding newborns and mental health and chemical dependency services
Nursing Facility	Claims	TBD	Nursing facility monthly claims
Emergency Department	Visits	TBD	Includes physician and hospital emergency department encounters
Dental		TBD	Non-institutional and hospital dental visits
Vision		TBD	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		TBD	Physician/practitioner and hospital outpatient visits
Behavioral Health	Service	TBD	Inpatient and outpatient behavioral encounters
Waiver		TBD	Professional Waiver services
Pharmacy	Prescriptions	TBD	Prescribed drugs

See Appendix N of this Provider Agreement, for the sanctions for noncompliance with the standards for this measure.

1.a.ii. Incomplete Rendering Provider Data

This measure is calculated per MCOP and includes all Ohio MCOP members receiving services from the MCOP. The *Incomplete Rendering Provider Data* measure is calculated to ensure that MCOPs are reporting individual-level rendering provider information to ODM, so that ODM complies with federal reporting requirements.

Measure: The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in the Medicaid Information Technology System (MITS).

Report Period:
The report periods for CY 2014 through CY 2017 contract periods are listed in Table 1above. Results for CY 2014 will be informational (reporting only). CY 2014 will be used as a baseline to set interim performance standards for CY 2015. Q1 and Q2 of CY 2015 will be used as a baseline to set performance standards for CY 2016 and CY 2017, with additional updates to be determined based on data submitted throughout CY 2015 through CY 2017.

Data Quality Standard:– TBD

See Appendix N of this Provider Agreement, for the sanctions for noncompliance with the standards for this measure.

1.a.iii. NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers

This measure is calculated per MCOP and includes all Ohio MCOP members receiving services from the MCOP. The *NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers* measure is calculated to ensure that providers reported on encounters can be associated with Medicaid and/or Reporting providers in MITS.

Measure: The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data field that do not have a Medicaid or Reporting Provider Number in MITS.

Report Period:
The report periods for CY 2014 through CY 2017 contract periods are listed in Table 1 above. Results for CY 2014 will be informational (reporting only). CY 2014 will be used as a baseline to set interim performance standards for CY 2015. Q1 and Q2 of CY 2015 will be used as a baseline to set performance standards for CY 2016 and CY 2017, with additional updates to be determined based on data submitted throughout CY 2015 through CY 2017.

Data Quality Standard:– TBD

See Appendix N of this Provider Agreement, for the sanctions for noncompliance with the standards for this measure.

1.a.iv. Rejected Encounters

Encounters submitted to ODM that are incomplete or inaccurate are rejected and reported back to the MCOPs on the Exception Report. If an MCOP does not resubmit rejected encounters, ODM's

encounter data set will be incomplete; therefore, MCOP shall resubmit the required data within the period of time specified by ODM.

These measures are calculated per MCOP and include all Ohio MCOP members receiving services from the MCOP.

1) Measure 1 - Measure 1 only applies to MCOPs that have had MCOP membership for more than one year.

Measure 1: The percentage of encounters submitted to ODM that are rejected

Report Period: Results for CY 2014 will be informational (reporting only). CY 2014 data will be used as a baseline to set data quality standards for CY 2015. For CY 2015 through CY 2017, the report periods will be quarterly.

Data Quality Standard for measure 1: The data quality standard for measure 1 is TBD for each file type in the ODM-specified medium per format.

See Appendix N of this Provider Agreement, for the sanctions for noncompliance with the standards for this measure.

2) Measure 2 - Measure 2 only applies to MCOPs that have had MCOP membership for one year or less.

Measure 2: The percentage of encounters submitted to ODM that are rejected.

Report Period: Results for CY 2014 will be informational (reporting only). CY 2014 data will be used as a baseline to set data quality standards for CY 2015. The report period for Measure 2 is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

Data Quality Standard for measure 2: The data quality standard for measure 2 is a maximum encounter data rejection rate for each file type in the ODM-specified medium per format as follows:

Third through sixth month with MCOP membership: TBD
Seventh through twelfth month with MCOP membership: TBD

See Appendix N of this Provider Agreement, for the sanctions for noncompliance with the standards for this measure.

1.b. Encounter Data Accuracy

As with data completeness, MCOPs are responsible for assuring the collection and submission of accurate data to ODM. Failure to do so jeopardizes MCOPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

1.b.i. Encounter Data Accuracy Study

Measure: This accuracy study will compare the accuracy and completeness of payment data stored in MCOPs' claims systems during the study period to payment data submitted to and accepted by ODM. The measure will be calculated per MCOP. Two levels of analysis will be conducted: one to evaluate encounter data completeness for which two rates will be calculated and one to evaluate payment data accuracy. Payment completeness and accuracy rates will be determined by aggregating data across claim types (i.e., professional, pharmacy, and institutional) and stratifying data by file type (i.e., header and detail). At a minimum, the additional components of analysis will include diagnosis codes and provider information (e.g., rendering provider, billing provider).

Encounter Data Completeness (Level 1):
Omission Encounter Rate: The percentage of encounters in an MCOP's fully adjudicated claims file not present in the ODM encounter data files.

Surplus Encounter Rate: The percentage of encounters in the ODM encounter data files not present in an MCOP's fully adjudicated claims files.

Payment Data Accuracy (Level 2):
Payment Error Rate: The percentage of matched encounters between the ODM encounter data files and an MCOP's fully adjudicated claims files where a payment amount discrepancy was identified.

Report Period: In order to provide timely feedback on the omission rate of encounters, the report period will be the most recent from when the study is initiated. This study is conducted annually.

Data Quality Standard for Measure 2:

For CY 2015:
For Level 1: An omission encounter rate and a surplus encounter rate of no more than 11% for both claim-level and line-level records.
For Level 2: A payment error rate of no more than 4%.

For CY 2016:
For Level 1: An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.
For Level 2: A payment error rate of no more than TBD.

For CY 2017:
For Level 1: An omission encounter rate and a surplus encounter rate of no more than TBD for both claim-level and line-level records.
For Level 2: A payment error rate of no more than TBD.

See Appendix N of this Provider Agreement for the sanctions for noncompliance with the standard for this measure.

1.c. Encounter Data Submission

Information concerning the proper submission of encounter data may be obtained from the *ODM ICDS Encounter Data Submission Specifications* document. Note: the *ODM MyCare Ohio Encounter Data Submission Specifications* include: encounter data companion guides for institutional, professional, and dental 837 EDI transactions; NCPDP D.0 files; 824 EDI response transactions; U277 EDI response transactions; *ODM MyCare Ohio Encounter Data Submission Guidelines*; *ODM MyCare Ohio Encounter Data Submission Schedule;* and *Encounter Data Letter of Certification*. The encounter data companion guides must be used in conjunction with the X12 Implementation Guide for EDI transactions.

1.c.i. Encounter Data Submission Procedure

The MCOP must submit encounter data files to ODM per the specified schedule and within the allotted amount established in the *ODM MyCare Ohio Encounter Data Submission Specifications.*

The MCOP must submit a letter of certification, using the form required by ODM, with each encounter data file in the ODM-specified medium per format.

The letter of certification must be signed by the MCOP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCOP's CEO or CFO (see *ODM MyCare Ohio Encounter Data Submission Specifications).*

See Appendix N of this Provider Agreement, for the sanctions for noncompliance with the standards for this measure.

1.c.ii. Timeliness of Encounter Data Submission

ODM recommends submitting MCP-paid encounters no later than thirty-five days after the end of the month in which they were paid. ODM currently monitors minimum encounter data claims volume (Section 1.a.i.) and rejected encounters (Section 1.a.iv.) and the standards for these measures are based on encounters being submitted within this time frame. Beginning in March 2015 for claims paid in January 2015, MCPs must report on encounter data submission lag time on a monthly basis to ODM. Results may be subject to an audit by ODM and/or a vendor representing ODM.

Effective SFY 2016 (July 2015), ODM will evaluate the timeliness of MCP encounter data submissions.

Measure: The percentage of encounters that are submitted to ODM and accepted within 60 calendar days of the month in which they were paid. (e.g., claims paid by the MCP in January 2015 would be reported after April 2th 2015).

Measurement Periods: TBD

Data Quality Standard: (effective 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: TBD

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. APPEALS AND GRIEVANCES DATA

Pursuant to OAC rule 5160-58-08.4, MCOPs 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 *Appeal File and Submission Specifications* and G*rievance File and Submission Specifications*.

The appeal data file and the grievance data file must include all appeal and grievance activity, respectively, for the previous month, and must be submitted by the ODM-specified due date. These data files must be submitted in the ODM-specified format and with the ODM-specified filename in order to be successfully processed.

MCOPs who fail to submit their monthly electronic data files to the ODM by the specified due date or who fail to resubmit, by no later than the end of that month, a file which meets the data quality requirements will be subject to penalty as stipulated in the Compliance Methodology.

3. UTILIZATION MANAGEMENT DATA

Pursuant to OAC rules 5160-58-01.1 and 5160-26-03.1, MCOPs are required to submit information on prior authorization requests as directed by ODM. ODM requires information on prior authorization requests to be submitted at least bi-weekly in electronic data file formats pursuant to the *Utilization Management Tracking Database: Prior Authorization File and Submission Specifications* document.

APPENDIX M

QUALITY MEASURES AND STANDARDS

The Ohio Department of Medicaid (ODM) has established Quality Measures and Standards to evaluate MyCare Ohio Plan (MCOP) performance in key program areas (i.e., access, clinical quality, consumer satisfaction). The selected measures align with specific priorities, goals, and focus areas of the ODM Quality Strategy. Each measure has a Minimum Performance Standard. Certain measures are used to determine the amount of the Medicaid quality withhold amount that an MCOP may earn back for a contract year per the Section 4 of the Three-Way Contract between the MCOP, CMS and ODM (the Three-Way),. For the remaining measures, failure to meet a Minimum Performance Standard will result in the assessment of a noncompliance penalty. See Appendix N of this Provider Agreement, for sanctions for noncompliance with the performance standards. The measures utilized for performance evaluation are derived from national measurement sets (e.g., HEDIS, AHRQ, HOS, CAHPS, MDS, CMS, etc.), widely used for evaluation of Medicaid/Medicare managed care industry data, and/or Ohio-specific measures designed to monitor goals associated with rebalancing initiatives which provide greater access to home and community based services, as an alternative to facility-based long-term care. Measures may apply either to those dual benefit members (opt-in population) and/or those Medicaid-only members (opt-out population). Performance measures and standards are subject to change based on the revision or update of applicable national measures, methods, benchmarks, or other factors as deemed relevant.

The performance measures listed in this Appendix are not intended to limit the assessment of other indicators of performance for quality improvement activities. MCOP performance based on multiple measures will be assessed and reported to the MCOPs and others, including Medicare and Medicaid consumers.

1. QUALITY MEASURES AND STANDARDS

MCOPs are evaluated on measures separately for dual benefit members (opt-in population) and the Medicaid-only members (opt-out population) using statewide population-specific results that include all regions in which the MCOP has membership. Results for each measure are calculated per MCOP and will either include all of the MCOP's Ohio dual benefit members (opt-in population) and/or Medicaid-only (opt-out population) per the criteria specified by the methodology for the given measure. Separate minimum performance standards may be established for the dual benefit population and the Medicaid-only population. MCOP performance is assessed using ODM calculated performance measurement data for the long term care measures, CMS calculated performance measurement data for the CMS measures, and results submitted to ODM and CMS by the MCOPs per issued by CMS for the HOS, HEDIS, and CAHPS measures. The long term care measures in this appendix are calculated in accordance with the methodology set forth in *ODM Methods for MyCare Ohio Long Term Care Quality Measures*.

1.a. Measures, Standards, and Measurement Periods

The measures and accompanying Minimum Performance Standards for the CY 2015, CY 2016, and CY 2017 measurement periods are listed in Table 1 below. The measurement set used to evaluate each measure is also provided. For sanctions associated with noncompliance with the performance

standards for these measures, see *Appendix N of this Provider Agreement*. Measures used to determine the Medicaid quality withhold amount that the MCOP may earn back for a contract year are located in the Three Way, Section 4, and are denoted with asterisks.

Table 1: MyCare Ohio Quality Performance Measures, Standards, and Measurement Periods

Quality Strategy Priority Area	Quality Strategy Goal	Clinical Focus Area	Measure	Measurement Set	Data Source	Consumer Population to which Measure Applies	CY 2015 Min Perf Std	CY 2016 Min Perf Std	CY 2017 Min Perf Std
Promote Evidence Based Prevention and Treatment Practices	Improve Health Care of Priority Populations	Behavioral Health	Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up**	NCQA/HEDIS	HEDIS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
		Behavioral Health	Screening for Clinical Depression and Follow-up**	CMS	HEDIS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
		Cardio-vascular Disease	Controlling High Blood Pressure **	NCQA/HEDIS	HEDIS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
		Diabetes	Comprehensive Diabetes Care - HbA1c Control (<8.0%)	NCQA/HEDIS	HEDIS	Dual Benefits Members (Opt-In)	NA	TBD	TBD
		Diabetes	Part D Medication Adherence for Diabetes Medications **	CMS	PDE Data	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
		Asthma/COPD	Flu Vaccinations for Adults Ages 65 and Older**	CAHPS	CAHPS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
		Musculoskeletal Health	Falls Risk Management **	NCQA/HEDIS/ HOS	HEDIS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
		Cancer Prevention	Breast Cancer Screening	NCQA/HEDIS	HEDIS	Dual Benefits Members (Opt-In)	NA	NA	TBD

Improve Care Coordination	Clear Communication, Accessible Care, Optimized Care	Integrating Care	Plan All Cause Readmissions**	NCQA/HEDIS	HEDIS	Dual Benefits Members (Opt-In)	NA	TBD	TBD
			Adults' Access to Preventive/Ambulatory Health Services	NCQA/HEDIS	HEDIS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
			Getting Appointments and Care Quickly*	CAHPS	CAHPS	Dual Benefits Members (Opt-In)	NA	TBD	TBD
			Satisfaction with Customer Service*	CAHPS	CAHPS	Dual Benefits Members (Opt-In)	NA	TBD	TBD
			Care for Older Adults - Medication Review, 66 & Older	NCQA/HEDIS	HEDIS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
			Care for Older Adults - Functional Status Assessment, 66 & Older	NCQA/HEDIS	HEDIS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
			Care for Older Adults -Pain Screening, 66 & Older	NCQA/HEDIS	HEDIS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD
			Health Status/Function Status-Survey	AHRQ/CAHPS	CAHPS	Dual Benefits Members (Opt-In)	TBD	TBD	TBD

Improve Care Coordination	Clear Communication, Accessible Care, Optimized Care	Improving and Rebalancing Long-Term Care	Nursing Facility Diversion Measure***	Ohio-Specific	MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	TBD	TBD	TBD
			Long Term Care Rebalancing Measure	Ohio-Specific	MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	TBD	TBD	TBD

			Long Term Care Overall Balance Measure**	Ohio-Specific	MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	TBD	TBD	TBD
			Percent of residents whose need for help with daily activities has increased	Ohio-Specific/NQF	MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	TBD	TBD	TBD
			Percent of residents who were physically restrained	Ohio-Specific/NQF	MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	TBD	TBD	TBD
			Percent of residents experiencing on or more falls with a major injury	Ohio-Specific/NQF	MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	TBD	TBD	TBD
			Percent of residents with urinary tract infection	Ohio-Specific/NQF	MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	TBD	TBD	TBD
			Percent of high-risk residents with pressure ulcers	Ohio-Specific/NQF	MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	TBD	TBD	TBD
			Percent of residents who have/had a catheter inserted and left in their bladder	Ohio-Specific/NQF	MDS	Dual Benefits Members (Opt-In) and Medicaid-Only Members (Opt-Out)	TBD	TBD	TBD

* Quality withhold measure for first contract year.
** Quality withhold measure for second and third contract years.

2. Reporting Requirements

2.a. Health Care Effectiveness Data and Information Set (HEDIS)

2.a.i. Annual Submission of HEDIS IDSS Data

MCOPs are required to collect, report, and submit to ODM self-reported, audited HEDIS data for the full set of HEDIS measures reported by the MCOP to NCQA for MyCare Ohio members per *ODM's Specifications for the Collection and Submission of MyCare Ohio Self-Reported, Audited HEDIS Results*. This must include all HEDIS measures reported to CMS by the MCOP. The self-reported, audited HEDIS data are due to ODM no later than five business days after the NCQA due date. In addition, MCOPs must report HEDIS measures per *CMS' Reporting Requirements for 2015 HEIDS, HOS and CAHPS Measures*.

See *Appendix N of this Provider Agreement*, for sanctions for noncompliance with this data submission requirement.

2.a.ii. Annual Submission of Final HEDIS Audit Report (FAR)

MCOPs are required to submit to ODM their FAR that contains the audited results for the full set of HEDIS measures reported by the MCOP to NCQA for Ohio MyCare Ohio members. This must include all HEDIS measures referenced in Appendix M. The FAR is due to ODM no later than five business days after the NCQA due date.

See *Appendix N of this Provider Agreement*, for sanctions for noncompliance with this data submission requirement.

Note: ODM will review each MCOP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. ODM reserves the right to pursue corrective action based on this review (see Appendix N of this Provider Agreement).

2.a.iii. Data Certification Requirements for HEDIS IDSS Data and Final HEDIS Audit Report

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

Each data certification letter is due to ODM on the same days that the respective HEDIS IDSS data/FAR are submitted to ODM. Additional specifications regarding the data certification letters will be made available in future technical guidance.

See *Appendix N of this Provider Agreement*, for sanctions for noncompliance with this data submission requirement.

2.b. Consumer Assessment of Health Plan Survey (CAHPS) Data

2.b.i. Annual Submission of CAHPS Data

MCOPs are required to collect, report, and submit to ODM CAHPS data for the full set of CAHPS measures reported to CMS by the MCOP for applicable MyCare Ohio members per *CMS' Reporting Requirements for 2015 HEIDS, HOS and CAHPS Measures*.

See *Appendix N of this Provider Agreement*, for sanctions for noncompliance with this data submission requirement.

2.c. Health Outcomes Survey (HOS) Data

2.c.i. Annual Submission of HOS Data

MCOPs are required to collect, report, and submit to ODM HOS data for the full set of HOS measures reported to CMS by the for applicable Ohio MyCare Ohio members per *CMS' Reporting Requirements for 2015 HEIDS, HOS and CAHPS Measures*.

See *Appendix N of this Provider Agreement*, for sanctions for noncompliance with this data submission requirement.

2.d. Nursing Facility 100-day Threshold and Discharge Data

2.d.i. Timely Submission of Nursing Facility 100-day Threshold and Discharge Data

MCOPs are required to collect, report, and submit nursing facility 100-day threshold and discharge data as specified in the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement*. The MCOP is responsible for submitting nursing facility 100-day threshold and discharge data files as required by ODM to comply with the MEMA timeframes documented in Appendix E of this Provider Agreement. The MCOP must also submit a letter of certification, using the form required by ODM, with each nursing facility admission and discharge data submission file.

ODM may use a statically valid sample of the NFLOC -data to determine compliance with the following minimum performance standards:

Minimum Performance Standard 1:

Timeliness: 95% of individual member records submitted within 30 business days of the NFLOC (100-day threshold) date and date of discharge, and in every care, NFLOC (100-day threshold) dates must be submitted in accordance with dates specified by ODM to comply with the MEMA timeframes specified in Appendix E.

Completeness and Accuracy: 95% of the individual member records 100-day threshold and discharge dates are complete and accurate as compared with associated medical records and in accordance with the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement*.

Reporting Periods: Quarterly

Minimum Performance Standard 2:

Timeliness: 99% of individual member records submitted within 30 business days after the member's NFLOC (100-day threshold) sate and date of discharge, and in every case, NFLOC (100-day threshold) dates must be submitted in accordance with dates specified by ODM to comply with the MEMA timeframes specified in Appendix E.

Completeness and Accuracy: 99% of the individual member records 100-day threshold and discharge dates are complete and accurate as compared with associated medical records and in accordance with the *MyCare Ohio Rules for Reporting the Institutional 100-Day Requirement*.

Reporting Periods: Annual

See *Appendix N of this Provider Agreement*, for sanctions for noncompliance with this data submission requirement.

3. NOTES

3.a. Measures and Measurement Periods

ODM reserves the right to revise the measures and measurement periods referenced in this Appendix (and their corresponding compliance periods), as needed, due to unforeseen circumstances. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining an MCOP's performance level for that contract period.

3.b. Performance Standards – Compliance Determination

In the event that an MCOP's performance cannot be evaluated for a performance measure and/or a measurement period referenced in this appendix, ODM will deem the MCOP to have met or to have not met the standard(s) for that particular measure and measurement period depending on the circumstances involved (e.g., if a HEDIS measure was assigned an audit result of "Not Report" on the MCOP's Final Audit Report and the "Not Report" designation was determined to be the result of a material bias caused by the MCOP, ODM would deem the MCOP to have not met the standard(s) for that measure and measurement period).

3.c. Performance Standards – Retrospective Adjustment

ODM will implement the use of a uniform methodology, as needed, for the retrospective adjustment of any Minimum Performance Standard referenced in this Appendix, except for the CAHPS measure standards. This methodology will be implemented at ODM's discretion when all three of the following criteria are met.

• The methodology for the standard's associated measure is revised. Note, for HEDIS measures, ODM will not adjust performance measure standards retrospectively due to procedural changes such as revisions to medical record hybrid review timelines.

• For the year in which the methodology is revised, the performance results for all Ohio MCOPs all increase or all decrease when compared to the standard-setting year. Note, this excludes MCOPs without results for both years.

• For the year in which the methodology is revised, the performance results for three or more MCOPs each change by at least three percentage points (e.g., increase from 56.0% to 59.0%) when compared to the standard-setting year.

For a comprehensive description of the standard adjustment methodology, see *ODM's MyCare Ohio Methods for the Retrospective Adjustment of Quality and Withhold Measure Standards.*

APPENDIX N

MYCARE OHIOCOMPLIANCE ASSESSMENT SYSTEM

I. General Provisions of the Compliance Assessment System

A. The Compliance Assessment System (CAS) sets forth sanctions that may be assessed by the Ohio Department of Medicaid (ODM) against the MyCare Ohio Plan (MCOP) if the MCOP is found to have violated the Three-Way Contract between ODM, CMS and the MCOP, this Provider Agreement, or applicable law. It does not in any way limit ODM from requiring Corrective Action Plans (CAPs) and program improvements, or from imposing any of the sanctions specified in OAC rule 5160-26-10 (applicable to MyCare Ohio pursuant to rule 5160-58-01.1) or any other additional compliance actions, including the proposed termination, amendment, or nonrenewal of this Provider Agreement.

B. As stipulated in OAC rule 5160-26-10, regardless of whether ODM imposes a sanction, the MCOP is required to initiate corrective action for any MCOP program violation or deficiency as soon as the violation or deficiency is identified by the MCOP or ODM. The MCOP is required to report to ODM when it becomes aware of any violation that could impair a member's ability to obtain correct information regarding services, impair member rights, affect the ability of the MCOP to deliver covered services, or affect the member's ability to access covered services.

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

D. Program violations that reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODM first becomes aware of this noncompliance.

E. ODM retains the right to use its discretion to determine and apply the most appropriate sanction based on the severity of the noncompliance, a pattern of repeated noncompliance, and number of beneficiaries affected.

F. ODM will issue all notices of noncompliance in writing to the identified MCOP contact.

G. Actions recommended or issued by the Contract Management Team (CMT) as defined in the Three-Way Contract in no way limit ODM's authority to impose sanctions and remedial actions under this Provider Agreement. ODM will take into consideration any sanctions or actions taken by the CMT when deciding whether and what type of sanctions/remedial actions to take for violations of this Provider Agreement.

II. Types of Sanctions/Remedial Actions

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

A. ODM Initiated Corrective Action Plans (CAPs)

A CAP is a structured activity, process or quality improvement initiative implemented by the MCOP to improve identified operational and clinical quality deficiencies.

MCOPs may be required to develop CAPs for any instance of noncompliance, and CAPs are not limited to actions taken in this Appendix. All CAPs requiring ongoing activity on the part of an MCOP to ensure its compliance with a program requirement remain in effect for twenty-four months, including CAPs issued under any Medicaid managed care provider agreement. All CAPs requiring implementation of quality improvement initiatives will remain in effect for at least twelve months from the date of implementation, including CAP's issued under any Medicaid managed care Provider Agreements.

Where ODM has determined the specific action which must be implemented by the MCOP or if the MCOP has failed to submit a CAP, ODM may require the MCOP to comply with an ODM-developed or "directed" CAP.

Where a sanction is assessed for a violation in which an MCOP has previously been assessed a CAP (or any sanction or any other related written correspondence), the MCOP may be assessed escalating sanctions.

B. Financial Sanctions

B.1. Financial Sanctions Assessed Due to Accumulated Points

On the effective date of the Three-Way between CMS, ODM and the MCOP, the MCOP shall begin with 0 points. Points will accumulate over a rolling 12-month schedule. Points more than 12 months old will expire.

No points will be assigned for a violation if an MCOP is able to document that the precipitating circumstances were completely beyond its control and could not have been foreseen (e.g., a construction crew severs a phone line, a lightning strike disables a computer system, etc.).

In cases where an MCOP-contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), ODM may assess points unless to the satisfaction of ODM: (1) the MCOP can document that it provided sufficient notification or education to providers of applicable program requirements and prohibited activities; and (2) the MCOP took immediate and appropriate action to correct the problem and to ensure that it will not reoccur. ODM will review repeated incidents and determine whether the MCOP has a systemic problem. If ODM determines that a systemic problem exists, further sanctions or remedial actions may be assessed against the MCOP.

B.1.2.1. 5 Points

ODM may in its discretion assess five (5) points when the MCOP 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 MCOP 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 MCOP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to staff a 24-hour call-in system with appropriate trained medical personnel.
- Failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Provision of false, inaccurate or materially misleading information to ODM, health care providers, the MCOP's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify ODM, or members, of provider panel terminations.
- Failure to update website provider directories as required.
- Failure to comply with a CAP.
- Failure to meet provider network performance standards.
- A violation of a care management process specified in Section 2.5.3 of the Three-Way, or Appendix K of the Provider Agreement that does not meet the standards for a 10 point violation. Examples include but are not limited to the following:
    - Failure to ensure that staff performing care management functions are operating within their professional scope of practice, are appropriately responding to a member's care management needs, or are complying with the state's licensure/credentialing requirements;
    - Failure to adequately assess an individual's needs including the evaluation of mandatory assessment domains;
    - Failure to update an assessment upon a change in health status, needs or significant health care event;
    - Failure to develop or update a care plan that appropriately addresses assessed needs of a member;
    - Failure to monitor the care plan;
    - Failure to complete a care gap analysis that identifies gaps between recommended care and care that is received by a member;
    - Failure to update the care plan in a timely manner when gaps in care or change in need are identified;

- Failure to coordinate care for a member across providers, specialists, and team members, as appropriate;
- Failure to adhere to a documented communication plan, including the contact schedule for in-person visits and telephone calls;
- Failure to make reasonable attempts to obtain a discharge/transition plan from an inpatient facility; conduct timely follow up with the member and provider, as appropriate; or arrange for services specified in the discharge/transition plan; or
- Failure to adhere to home and community-based services (HCBS) waiver service coordination and operational requirements in the Three-Way, Section 2.5.3.3.5.4, and the Ohio approved HCBS 1915(c) waiver for MyCare Ohio.

B.1.2.2. 10 Points

ODM may assess ten (10) points when an MCOP fails to meet a program requirement that could, as determined by ODM: (1) affect the ability of the MCOP to deliver, or a member to access, covered services; (2) place a member at risk for a negative health outcome; or (3) jeopardize the safety and welfare of a member. Examples include, but are not limited to, the following:

- Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).
- Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member.
- Failure to provide medically-necessary Medicare or Medicaid covered services to members.
- Failure to process prior authorization requests within the prescribed time frames.
- Repeated failure to comply with a CAP action.
- The imposition of premiums or charges on members that are in excess of the premiums or charges permitted under the MyCare Ohio demonstration project.
- Misrepresentation or falsification of information that the MCOP furnishes to ODM.
- Misrepresentation or falsification of information that the MCOP furnishes to a member, potential member, or health care provider.
- Failure to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
- Violation of a care management process, including HCBS 1915(c) waiver operations, as specified in the Three-Way, Section 2.5.3 or the Provider Agreement Appendix K.

B.1.2.3. Progressive Sanctions Based on Accumulated Points

Progressive sanctions will be based on the number of points accumulated at the time of the most recent incident. A CAP or other sanction may be imposed in addition to the fines listed below. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	CAP + No fine
16-25 Points	CAP + $5,000 fine
26-50 Points	CAP + $10,000 fine
51-70 Points	CAP + $20,000 fine
71-100 Points	CAP + $30,000 fine
100+ Points	Proposed Provider Agreement Termination

B.2 Specific Pre-Determined Sanctions

B.2.1. Adequate network-minimum provider panel requirements

Any deficiencies in an MCOP's provider network specified the Provider Agreement or the Three-Way may result in the assessment of a $1,000 nonrefundable fine for each category (dental, vision, waiver providers etc.) and for each county/zip code. Compliance will be assessed at least quarterly.

ODM may assess additional sanctions (e.g. CAPs, points, fines) if (1) an MCOP violates any other provider panel requirements contained within either the Three-Way or Medicaid provider agreement or (2) an MCOP's member has experienced problems in accessing necessary services because of noncompliance by a provider within the MCOP's panel.

B.2.2. Late Submissions

All submissions, data and documentation submitted by an MCOP must be received by ODM within the specified deadline and must represent the MCOP in an honest and forthright manner. If the MCOP fails to provide ODM with any required submission, data or documentation, ODM may assess a nonrefundable fine of $100 per day, unless the MCOP requests and is granted an extension by ODM. Assessments for late submissions will be done monthly.

If an MCOP is unable to meet a program deadline or data/documentation submission deadline, the MCOP must submit a written request to its Contract Administrator for an extension of the deadline, as soon as possible, but no later than 3 PM, EST, on the date of the deadline in question. Requests for extensions should only be submitted where unforeseeable circumstances have made it impossible for the MCOP to meet a deadline stipulated by ODM. All such requests will be

evaluated upon this standard. ODM may assess a compliance action against an entity, unless written approval for an extension of the deadline has been granted.

B.2.3. Noncompliance with Claims Adjudication Requirements

If ODM finds that an MCOP is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, ODM may assess the MCOP with a monetary sanction of $20,000 per day for the period of noncompliance. Additionally, the MCOP may be assessed 5 points per incident of noncompliance.

B.2.4 Noncompliance with Financial Performance Measures and/or the Submission of Financial Statements

If the MCOP fails to meet any financial performance measure set forth in Sections 2.13 or 4.2.6 of the Three-Way or fails to submit to the Ohio Department of Insurance (ODI) financial statements by the due date set by ODI, then ODM may impose upon the MCOP a CAP, or a freeze on the enrollment of new members, or both. The MCOP shall submit financial statements to ODM by ODI's originally specified due date unless ODM grants an extension to the MCOP in writing.

B.2.5 Noncompliance with Reinsurance Requirements

If ODM determines that (1) an MCOP has failed to maintain reinsurance coverage as set forth in 2.13.4. of the Three-Way, (2) an MCOP's deductible exceeds $100,000 without approval from ODM, or (3) an MCOP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODM, then ODM may require the MCOP to pay a monetary sanction to ODM. The amount of the sanction will be the lesser of (1) 10% of the difference between the estimated amount of what the MCOP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCOP actually paid while it was out of compliance or (2) $50,000.

If ODM determines that an MCOP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, ODM may subject the MCOP to a CAP.

B.2.6 Noncompliance with Prompt Payment

ODM may impose progressive sanctions on an MCOP that does not comply with the prompt pay requirements as specified 42 CFR 447.46 and Section 5.1.9 of the Three-Way. 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 MCOP'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 MCOP complies with the required standards for two (2) consecutive quarters. Subsequent violations may result in an enrollment freeze.

If ODM finds that an MCOP has not complied with the prompt pay requirements for any time period for which a report and signed attestation have been submitted representing the MCOP as

being in compliance, ODM may subject the MCOP to an enrollment freeze of not less than three (3) months duration.

B.2.7. Noncompliance with Clinical Laboratory Improvement Amendments (CLIA)
If an MCOP fails to comply with CLIA requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of a $1,000 for each documented violation.

B.2.8. Noncompliance with Abortion and Sterilization Hysterectomy Requirements
If an MCOP fails to comply with abortion and sterilization requirements as specified by ODM, then ODM may impose a nonrefundable fine in the amount of $2,000 for each documented violation. Additionally, MCOPs must take all appropriate action to correct each violation documented by ODM.

B.2.9. Refusal to Comply with Program Requirements
If ODM has instructed an MCOP that it must comply with a specific program requirement and the MCOP refuses, such refusal constitutes documentation that the MCOP is no longer operating in the best interests of the MCOP's members or the state of Ohio, and ODM may move to terminate or non-renew the MCOP's provider agreement.

B.2.10. Reporting Requirements for Data and Measurement Sets for Quality Measures

B.2.10.1 Reporting Requirements

B.2.10.1.1. Annual Submission of MCOP Self-Reported, Audited HEDIS Data
Performance is monitored annually. If an MCOP fails to submit its self-reported, audited HEDIS data as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the self-reported, audited HEDIS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of the Provider Agreement for the corresponding contract period.

B.2.10.1.2 Annual Submission of Final HEDIS Audit Report (FAR)
Performance is monitored annually. If an MCOP fails to submit its FAR as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the self-reported, audited HEDIS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of the Provider Agreement for the corresponding contract period.

ODM will review each MCOP's FAR in order to determine if any data collection or reporting issues were identified. In addition, ODM will evaluate any issues that

resulted in the assignment of an audit result of "Not Report" (i.e., NR) for any measure. An MCOP may be required to submit to ODM requested documentation to account for an NR audit designation. Based on its review of an MCOP's FAR and any NR audit designations assigned, ODM may impose corrective action (such as requiring the MCOP to implement a corrective action plan to resolve data collection and/or reporting issues).

B.2.10.1.3. Data Certification Requirements for HEDIS IDSS Data and HEDIS Audit Report

Performance is monitored annually. If an MCOP fails to submit a required data certification letter to ODM within the required time frame, CMS or ODM may impose a nonrefundable fine of $100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.10.1.4. Annual CAHPS Survey Administration and Data Submission

Performance is monitored annually. ODM may impose a non-refundable $300,000 monetary sanction if an MCOP fails to administer a CAHPS survey and submit the survey data to any of the following entities: (1) NCQA, (2) the CAHPS Database, (3) ODM, or (4) a designee specified by ODM. In addition, the MCOP will be considered non-compliant with the standards for all of the CAHPS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three-Way and in Appendix O of the Provider Agreement for the corresponding contract period.

B.2.10.1.5. CAHPS Data Certification Requirements

Performance is monitored annually. If an MCOP fails to submit a required CAHPS data certification letter to ODM within the required time frame, CMS or ODM may impose a nonrefundable fine of $100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.10.1.6. Annual Submission of MCOP Health Outcomes Survey (HOS) Results

Performance is monitored annually. If an MCOP fails to submit its HOS data as specified by ODM, the MCOP will be considered non-compliant with the standards for all of the HOS performance measures in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement for the corresponding contract period. In addition, the MCOP will be disqualified from receiving all or a portion of the quality withholds as specified in the Three Way and in Appendix O of the Provider Agreement for the corresponding contract period.

B.2.10.1.7. Complete and Accurate Submission of Nursing Facility 100-Day Threshold and Discharge Data

Performance may be monitored quarterly and annually. The nursing facility admission and discharge data set may be subject to an audit for completeness and accuracy by ODM, or a vendor contracted by ODM. Any overpayments made by ODM to the MCOP as a result of inaccurate or incomplete nursing facility 100-day threshold or discharge data submitted by the MCOP will result in ODM recouping the overpayment(s).

If an MCOP fails to submit complete and accurate nursing facility 100-day threshold and discharge data as specified by ODM, the MCOP will be considered non-compliant with the standards established in Appendix M of the MyCare Ohio Provider Agreement for the corresponding contract period. ODM may issue the following sanctions:

- 1st instance, or subsequent but nonconsecutive instance, or noncompliance-ODM may impose a non-refundable monetary sanction in the amount of one quarter of one percent of the current month's premium payment.
- 2nd consecutive instance of noncompliance-ODM may impose a non-refundable monetary sanction on the amount of one half of one percent of the current month's premium payment.
- 3rd consecutive instance of noncompliance-ODM may terminate the MCOP's Provider Agreement.

B.2.10.2. Data Quality Measures

The MCOP must submit to ODM, by the specified deadline and according to specifications set by ODM, all required data files and requested documentation needed to calculate each measure listed below. If an MCOP fails to comply with this requirement for any measure listed below, the MCOP will be considered noncompliant with the standard(s) for that measure. Data quality report periods, measures, standards and requirements are specified in Appendix L of the Provider Agreement and *ODM Measures for the MyCare Ohio Encounter Data Quality Measures*.

ODM reserves the right to withhold an assessment of noncompliance under this section due to unforeseeable circumstances.

The monetary sanction for each measure listed below shall not exceed $300,000 during each evaluation period.

Sanctions for noncompliance are assessed for each MCOP as described for each measure.

B.2.10.2.1 Encounter Data Volume

Performance is monitored once every quarter for the entire measurement period for each of the following populations and service combinations: 1) Medicaid and Medicare services for dual benefit members; and 2) Medicaid services for Medicaid-only

members. Sanctions for non-compliance will be assessed separately, by population and service combination. For each population (i.e., dual benefit members vs. Medicaid-only members) and service combination (i.e., Medicaid vs. Medicare), if the standard is not met for every service category in all quarters of the measurement period, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the current month's premium payment. If an MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze. Once the MCOP 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.2.10.2.2. Encounter Data Accuracy

B.2.10.2.2.1 Rejected Encounters

Performance is monitored once every quarter for Measure 1 and once every month for Measure 2 in Appendix L of the Provider Agreement. Compliance determination with the standard applies only to the measurement period under consideration and does not include performance in previous measurement periods. Files in the ODM-specified medium per format that are totally rejected will not be considered in the determination of noncompliance. If the standard is not met for every file type, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the current month's premium payment. If an MCOP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Once the MCOP 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 MCOPs with less than 1,000 members.

B.2.10.2.2.3. Acceptance Rate

Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months. If the standard is not met for every file type, the MCOP will be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive measurement period, ODM may impose a monetary sanction of two percent of the current month's premium payment. If an MCOP is determined to be noncompliant with the standard in a third, consecutive measurement period, ODM may impose a new member enrollment freeze. Once the MCOP 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 MCOPs with less than 1,000 members.

B.2.10.2.2.4. Payment Accuracy Measure

The first time an MCOP is determined to be noncompliant with the standard for either level 1 or level 2 for this measure, the MCOP must implement a CAP which identifies interventions and a timeline for resolving data quality issues related to payments. Additional reports to ODM addressing targeted areas of deficiencies and progress implementing data quality improvement activities may be required. Upon all subsequent measurements of performance, if an MCOP is again determined to be noncompliant with the standard for either level 1 or level 2 for this measure, ODM may impose a monetary sanction of one percent of the current month's premium payment. Once the MCOP 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 may be returned.

B.2.10.2.2.5. Incomplete Rendering Provider Data

Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCOP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the current month's premium payment. If an MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze. Once the MCOP 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.2.10.2.2.6. NPI Provider Number Usage without Medicaid/Reporting Provider Numbers

Performance is monitored once every quarter for all measurement periods. If the standard is not met in all quarters of the measurement period, the MCOP may be determined to be noncompliant for the measurement period.

ODM may issue a CAP for all instances of noncompliance with this measure that are NOT consecutive. ODM may issue a series of progressive sanctions for consecutive instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may issue a CAP. If an MCOP is determined to be noncompliant with the standard in a second, consecutive quarter, ODM may impose a monetary sanction of two percent of the current month's premium payment. If an MCOP is determined to be noncompliant with the standard in a third, consecutive quarter, ODM may impose a new member enrollment freeze. Once the MCOP 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.2.10.2.7 Encounter Submissions per *ODM Encounter Data Submission Schedule*

Performance is monitored once every month. If the standard is not met for the measurement period, the MCOP will be noncompliant for the measurement period.

Effective January 2015, ODM will issue a series of progressive sanctions for all instances of noncompliance. The first time an MCOP is determined to be noncompliant with the standard for this measure, ODM may impose a monetary sanction of one percent of the current month's premium and delivery payments. If an MCOP is determined to be noncompliant with the standard in any subsequent month, consecutive or non-consecutive, ODM will impose a monetary sanction of two percent of the current month's premium

and delivery payments. Once the MCOP 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.2.10.3 Performance Evaluation Measures

The MCOP must submit to ODM, by the specified deadline and according to specifications set by ODM, all required data files and requested documentation needed to assess the performance evaluation measures specified in Appendix M of the Provider Agreement. If an MCOP fails to comply with this requirement for any performance measure listed in Appendix M of the Provider Agreement, the MCOP will be considered noncompliant with the standard(s) for that measure.

ODM reserves the right to withhold an assessment of noncompliance under this Section due to unforeseeable circumstances.

For each measure and population (i.e., dual benefit members and Medicaid-only members) as specified in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of the Provider Agreement, one rate is calculated. Each rate per specified population has an associated Minimum Performance Standard. When an MCOP fails to meet a Minimum Performance Standard listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of the Provider Agreement, for a measure and specified population for which noncompliance sanctions are applicable, the MCOP will be assessed a sanction for noncompliance with the standard. ODM have established uniform noncompliance sanctions for these standards.

A series of progressive sanctions may be issued for consecutive instances of noncompliance with the standard established for a given rate and population. For example, two rates, corresponding to the dual benefit member population and Medicaid-only member population, are calculated for the *Long-Term Care Overall Balance* measure. An MCOP failing to meet the standard established for the dual benefit member population rate in three consecutive measurement periods would be subject to progressive sanctions. However, an MCOP failing to meet the standard established for the dual benefits member population rate in one measurement period and the Medicaid-only member population in the next would not be subject to progressive sanctions, as these only apply to the standard established for the same population.

For the standard established for each rate and specified population listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* as referenced in Appendix M of the Provider Agreement, for measures for which noncompliance sanctions are applicable, an MCOP may be assessed sanctions for instances of noncompliance as follows:

- **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 payment. Once the MCOP 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 payment. 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 payment. This is non-refundable.

Additionally, if ODM determine that an MCOP is noncompliant with greater than 50% of the applicable performance evaluation standards listed in *MyCare Ohio Quality Performance Measures, Standards and Measurement Periods* referenced in Appendix M of the Provider Agreement, for which noncompliance sanctions are applicable, for two consecutive contract years, ODM may terminate the MCOP's Provider Agreement.

B.2.10.5. Administrative Compliance Assessment

Compliance with administrative standards is performed by the external quality review organization, as specified by ODM. For each documented instance of noncompliance with an administrative standard, the MCOP may be required to submit a corrective action as specified by ODM to remedy the identified deficiency.

B.2.10.6 Care Management Data Submission

The MCOP must submit to ODM all required care management data as specified in ODM's *MyCare Ohio Care Management Data Submission Specifications*. If an MCOP fails to comply with the timely submission requirement, then ODM may impose a nonrefundable fine of $100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.10.6.1. Care Management Data Certification Requirements

If an MCOP fails to submit a required Care Management data certification letter to ODM within the required time frame, ODM may impose a nonrefundable fine of $100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.10.7 HCBS Waiver Operational Reporting Requirements

The MCOP must submit to ODM all required HCBS waiver operational reporting requirements as specified by ODM or CMS or both. If an MCOP fails to submit a required reporting to ODM within the required time frame, CMS or ODM may impose a nonrefundable fine of $100 per day, unless the MCOP requests and is granted an extension by ODM.

B.2.10.8. Care Management Staffing Ratio

ODM may assess sanctions on the MCOP for instances of non-compliance with the care management staffing ratio standards specified in Appendix K.1.e.ii. of the Provider Agreement 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 payment. Once the MCOP 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 payment. 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 payment. This amount is non-refundable.

- 4th consecutive instance of noncompliance: ODM may terminate the MCOP provider agreement.

B.2.10.9 Comprehensive Assessment measures: For the standard established for each measure listed in Appendix K.1.iii.g, an MCOP may be assessed sanctions for instances of non-compliance 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 payment. This amount is non-refundable.
- 2nd 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 payment. This amount is non-refundable.
- 3rd consecutive instance of noncompliance – ODM may impose a sanction in the amount of three-quarters of one percent of the current month's premium payment. This amount is non-refundable.
- 4th consecutive instance of noncompliance – ODM may terminate the MCOP's provider agreement.

B.2.10.10. Maintenance of National Committee for Quality Assurance Health Plan Accreditation

For the standard established in Section 2.2.4 of the Three-Way, ODM may assess the following sanctions for non-compliance:

If the MCOP receives a Provisional accreditation status, the MCOP will be required to complete a resurvey within 12 months of the accreditation decision. If the resurvey results in a Provisional or Denied status, ODM will consider this a material breach of the provider agreement and may terminate the provider agreement with the MCOP.

If the MCOP receives a Denied accreditation status, then ODM will consider this a material breach of the provider agreement and may terminate the provider agreement with the MCOP.

B.2.3

Fines

Refundable or nonrefundable fines may be assessed separately or in combination with other sanctions/remedial actions. The total fines assessed in any one month will not exceed 15% of one month's payment from ODM to the MCOP. Unless otherwise stated, all fines are nonrefundable.

B.2.3.1 Refundable and nonrefundable monetary sanctions/assurances must be paid by the MCOP to ODM within thirty (30) calendar days of receipt of the invoice by the MCOP, or as otherwise directed by ODM in writing. In addition, per ORC Section 131.02, payments owed to the State not received within forty-five (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 MCOP payments certified to the AG's Office.

B.2.3.2. Monetary sanctions imposed by ODM will be based on the most recent premium payments in the month of the cited deficiency.

B.2.3.3. Any monies collected through the imposition of a refundable fine will be returned to the MCOP (minus any applicable collection fees owed to the AG's Office if the MCOP has been delinquent in submitting payment) after it has demonstrated full compliance with the particular program requirement, as determined by ODM.

B.2.3.4. An MCOP is required to submit a written request for refund to ODM at the time it believes is appropriate before a refund of monies will be considered.

B.3. New Enrollment Freezes

Notwithstanding any other sanction or point assessment that ODM may impose on the MCOP under this Provider Agreement, ODM may prohibit an MCOP from receiving new enrollment through consumer initiated selection or the assignment process if any of the following occur: (1) the MCOP has accumulated a total of 51 or more points during a rolling 12-month period; (2) the MCOP has failed to fully implement a plan of correction within the designated time frame; (3) circumstances exist that potentially jeopardize the MCOP's members' access to care, as solely determined by ODM; or (4) the MCOP is found to have a pattern of repeated or ongoing noncompliance, as solely determined by ODM. Examples of circumstances that ODM may consider as jeopardizing member access to care include, but are not limited to, the following:

- The MCOP has been found by ODM to be noncompliant with the prompt payment or the non-contracting provider payment requirements;
- The MCOP has been found by ODM to be noncompliant with the provider panel requirements specified in Appendix H of the Provider Agreement;
- The MCOP has refused to comply with a program requirement after ODM has directed the MCOP to comply with the specific program requirement;
- The MCOP has received notice of proposed or implemented adverse action by the ODI; or
- The MCOP has failed to provide adequate provider or administrative capacity.

Payments provided for under the Provider Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.730.

B.4. Reduction of Assignments

ODM has discretion over how member auto-assignments are made. ODM may reduce the number of assignments an MCOP receives to assure program stability within a region, or upon a determination that the MCOP lacks sufficient capacity to meet the needs of the increased enrollment volume. ODM may determine that an MCOP has demonstrated a lack of sufficient capacity under circumstances that include, but are not limited to the following:

- The MCOP has failed to maintain an adequate provider network;
- The MCOP has failed to provide new member materials by the member's effective date;
- The MCOP has failed to meet the minimum call center requirements;
- The MCOP has failed to meet the minimum performance standards for members with special health care needs; or
- The MCOP has failed to provide complete and accurate data files regarding appeals or grievances, or its Care Management System (CAMS) files.

B.5. Death or Injury to Member

ODM may immediately terminate or suspend this Agreement if an MCOP's failure to perform, or properly perform, any of the requirements in this Agreement results in the death of or serious injury to, an MCOP's member, as determined by ODM.

III. Request for Reconsiderations

An MCOP may seek reconsideration of ODM sanctions/remedial actions that result in the imposition of points, fines, and member enrollment freezes. MCOPs may not seek reconsideration of ODM actions that result in changes to the auto-assignment of members and the imposition of directed CAPs. The MCOP must submit a request for reconsideration on the form required by ODM, in accordance with the following procedure:

A. An MCOP 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 MCOP. The MCOP 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 MCOP must submit a request for reconsideration either by email to the designated Contract Administrator (CA), or by overnight mail to ODM's Bureau of Managed Care (BMC). The request for reconsideration must be received by ODM no later than the tenth business day after the date that the MCOP receives notice of the imposition of the remedial action by ODM.

C. A request for reconsideration must explain in detail why the specified sanction should not be imposed. In considering an MCOP's request for reconsideration, ODM will review only the written material submitted by the MCOP.

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 MCOP, a final reconsideration decision will be made within three (3) business days after the date by which the MCOP is required to submit the additional information. If ODM requires additional time in rendering the final reconsideration decision, the MCOP 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 MCOP, both the sanction and the points associated with the incident may be rescinded or reduced, at the discretion of ODM. The MCOP may still be required to submit a CAP if ODM, in its discretion, believes that a CAP is still warranted under the circumstances.

APPENDIX O

QUALITY WITHHOLDS

Dual Benefit Members Quality Withhold Policies and Measures
Section 4 of the Three-Way Contract between MCOP, CMS and ODM (the Three-Way) specifies the Quality Withhold policies and measures for the dual benefit members (opt-in population). For the dual benefit members (opt-in population), the quality withhold methodology is specified in *CMS' Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes (DY 1)* for Demonstration Year 1.

Medicaid-Only Quality Withhold Policies and Measures
ODM will withhold a percentage of the MCOP's Medicaid-only (opt-out population) capitation rate. The withheld amounts will be repaid subject to the MCOP's performance consistent with established quality thresholds. ODM will evaluate the MCOP's performance according to the specified metrics required in order to earn back the quality withhold for a given year. Table 1. below identifies the withhold measure for the Medicaid-only members (opt-out population) for Demonstration Year 1. This measure will be for a one percent (1%) withhold Because Demonstration Year 1 crosses calendar and contract years, the MCOP will be evaluated to determine whether it has met required withhold requirements at the end of both Calendar Year (CY) 2014 and CY 2015. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year. The quality withhold will increase to two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Year 3. Payments will be based on performance on the quality withhold measures listed in Table 2.

Table 1. Quality Withhold Measures for Demonstration Year 1 for Medicaid-Only Members

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Nursing Facility Diversion Measure	Reporting of the number of Beneficiaries who lived outside the NF during the current measurement year as a proportion of the Beneficiaries who lived	State-defined measure		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
	outside the NF during the previous year. Nursing Facility Diversion Rate: Numerator: of those Beneficiaries in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. Denominator: Beneficiaries enrolled in MCOP eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any Beneficiary with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.			

Table 2. Quality Withhold Measures for Demonstration Years 2 and 3 for Medicaid-Only Members

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Nursing Facility Diversion Measure	Reporting of the number of Beneficiaries who lived outside the NF during the current measurement year as a proportion	State-defined measure		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
	of the Beneficiaries who lived outside the NF during the previous year. Nursing Facility Diversion Rate: Numerator: of those Beneficiaries in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. Denominator: Beneficiaries enrolled in MCOP eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any Beneficiaries with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.			
Long Term Care Overall Balance Measure	Reporting of the number of Beneficiaries who did not reside in a NF as a proportion of the total number of Beneficiaries in an MCOP. Numerator: of those Beneficiaries in the denominator, those who did not reside for more than 100 continuous days in a NF during the current measurement year. Denominator: Beneficiaries in an MCOP eleven out of twelve months during the current measurement year.	State-defined measure		X

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
	Exclusions: Any Beneficiary with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.			

For Medicaid-only members (opt-out population), additional specifications regarding the quality withholds, including more detailed specifications, required thresholds and other information regarding the methodology will be made available in future technical guidance.

APPENDIX P

TERMINATION/NONRENEWAL

1 . PLAN-INITIATED TERMINATIONS/NONRENEWALS

If a MyCare Ohio Plan (MCOP) provides notice of the termination/nonrenewal of this Provider Agreement to ODM, pursuant to Article VIII of this MCOP Provider Agreement (Agreement) or Section 5.5 of the Three-Way Contract (Three-Way) between United States Department of Health and Human Services Centers for Medicare and Medicaid Services, ODM and the MCOP, the MCOP will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

The MCOP agrees to fulfill all duties and obligations as required under Chapter 5160-58 of the Administrative Code and any agreements related to the provision of services for the Medicaid population during periods of time when the MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCOP for the MCOP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCOP for the MCOP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCOP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5% of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCOP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM).* The MCOP must contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the monetary assurance is not received as specified above, ODM may withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement, the monetary assurance will not be refunded to the MCOP.

c Withhold Amount

Any withhold amount in the managed care program performance payment fund will be retained by ODM.

d. Final Accounting of Amounts Outstanding

The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. Data Files

In order to assist members with continuity of care, the terminating MCOP must create data files to be shared with each newly enrolling MCOP. The data files must be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, pregnant members, and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The terminating MCOP will be responsible for ensuring the accuracy and data quality of the files.

g. Notification

i. Provider Notification - The MCOP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.

ii. Member Notification – Unless otherwise notified by ODM, the MCOP must notify its members regarding its provider agreement termination at least 45 days

in advance of the effective date of termination. The member notification must be approved by ODM prior to distribution.

iii. Prior Authorization Re-Direction Notification - The MCOP must create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCOP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCOP must utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCOP membership.

2. ODM-INITIATED TERMINATIONS FOR CAUSE

a. If ODM initiates the proposed termination, nonrenewal or amendment of this Agreement pursuant to OAC rules 5160-58-01.1 and 5160-26-10 by issuing a proposed adjudication order pursuant to O.R.C. 5164.38, and the MCOP submits a valid appeal of that proposed action pursuant to O.R.C. Chapter 119, the MCOP's provider agreement will be extended through the issuance of an adjudication order in the MCOP's appeal under ORC Chapter 119.

During this time, the MCOP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation under Appendix N of the provider agreement. If the MCOP exceeds 69 points, each subsequent point accrual will result in a $15,000 nonrefundable fine.

Pursuant to OAC rules 5160-58-01.1 and 5160-26-10, if ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODM may notify the MCOP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCOP without cause. If ODM has proposed the termination, nonrenewal, denial or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODM may propose to terminate the membership of all of the MCOP's members. The appeal process for reconsideration of the proposed termination of members is as follows:

- All notifications of such a proposed MCOP membership termination will be made by ODM via certified or overnight mail to the identified MCOP Contact.

- An MCOP notified by ODM of such a proposed MCOP membership termination will have three working days from the date of receipt to request reconsideration.

- All reconsideration requests must be submitted by either facsimile transmission or

overnight mail to the Director, Ohio Department of Medicaid, and received by 3PM Eastern Time on the third working day following receipt of the ODM notification of termination. The address and fax number to be used in making these requests will be specified in the ODM notification of termination document.

- The MCOP will be responsible for verifying timely receipt of all reconsideration requests. All requests must explain in detail why the proposed MCOP membership termination is not justified. The MCOP's justification for reconsideration will be limited to a review of the written material submitted by the MCOP.

- A final decision or request for additional information will be made by the Director within three working days of receipt of the request for reconsideration. Should the Director require additional time in rendering the final reconsideration decision, the MCOP will be notified of such in writing.

- The proposed MCOP membership termination will not occur while an appeal is under review and pending the Director's decision. If the Director denies the appeal, the MCOP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODM determines that it would be in the best interest of the members.

b. Fulfill Existing Duties and Obligations

The MCOP agrees to fulfill all duties and obligations as required under Chapter 5160-58 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population during periods of time when MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid population after the termination/nonrenewal date, resolution of provider and consumer complaints for the Medicaid population served by the MCOP for the MCOP provider agreement time periods, and provision of data to support audits related to the Medicaid population served by the MCOP for the MCOP's provider agreement time periods.

c. Refundable Monetary Assurance

The MCOP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODM in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCOP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM)*. The MCOP must contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP must send copies of the EFT bank confirmations and copies of the invoices to its Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, the MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement, the monetary assurance will not be refunded to the MCOP.

d. Withhold Amount

Any withhold amount in the managed care program performance payment fund will be retained by ODM.

e. Monetary Sanctions

All previously collected refundable monetary sanctions shall be retained by ODM.

f. Final Accounting of Amounts Outstanding

The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after the termination/nonrenewal date. Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

g. Data Files

In order to assist members with continuity of care, the terminating MCOP must create data files to be shared with each newly enrolling MCOP. The data files must be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, pregnant members and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The terminating MCOP will be responsible for ensuring the accuracy and data quality of the files.

h. Notification

i. Provider Notification - The MCOP must notify contracted providers at least 55 days prior to the effective date of termination. The provider notification must be approved by ODM prior to distribution.

ii. Prior Authorization Re-Direction Notification - The MCOP must create two notices to assist members and providers with prior authorization requests received and/or approved during the last month of membership. The first notice is for prior authorization requests for services to be provided after the effective date of termination; this notice will direct members and providers to contact the enrolling MCOP. The second notice is for prior authorization requests for services to be provided before and after the effective date of termination. The MCOP must utilize ODM model language to create the notices and receive approval by ODM prior to distribution. The notices will be mailed to the provider and copied to the member for all requests received during the last month of MCOP membership.

3. TERMINATION OR MODIFICATION OF THIS PROVIDER AGREEMENT DUE TO LACK OF FUNDING

Should this Agreement terminate or be modified due to a lack of available funding as set forth in the Baseline of this Agreement, the MCOP has no right to appeal the selection process under ORC Chapter 119 pursuant to ORC 5164.38 and will be required to comply with the following:

a. Fulfill Existing Duties and Obligations

The MCOP agrees to fulfill all duties and obligations as required under Chapter 5160-58 of the Administrative Code and any provider agreements related to the provision of services for the Medicaid population(s) during periods of time when the MCOP was under contract with ODM. Such duties and obligations include, but are not limited to, the submission by the MCOP of any previously reported appeals and grievances data which were unresolved for the Medicaid populations, resolution of provider and consumer complaints for the Medicaid population served by the MCOP for the MCOP provider agreement time periods, and provision of data to support audits related to the Medicaid

population served by the MCOP for the MCOP's provider agreement time periods.

b. Refundable Monetary Assurance

The MCOP will be required to submit a refundable monetary assurance should the Provider Agreement terminate. This monetary assurance will be held by ODM until such time that the MCOP has submitted all outstanding monies owed, data files, and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODM in the month the termination notice is issued, whichever is greater.

The MCOP must remit the monetary assurance in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State, State of Ohio (ODM).* The MCOP must contact its Contract Administrator to verify the correct amounts required for the monetary assurance and obtain an invoice number prior to submitting the monetary assurance. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODM Fund account. In addition, the MCOP must send copies of the EFT bank confirmations and copies of the invoices to its Contract Administrator.

If the monetary assurance is not received as specified above, ODM will withhold the MCOP's next month's capitation payment until such time that ODM receives documentation that the monetary assurance has been received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCOP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, fines or sanctions, encounter and cost report data related to time periods through the final date of service under the MCOP's provider agreement, the monetary assurance will not be refunded to the MCOP.

c. Withhold Amount

Any withhold amount in the managed care program performance payment fund will be awarded by ODM in accordance with the pay-for-performance system set forth in Appendix O for the current provider agreement year.

d. Monetary Sanctions

Previously collected refundable monetary sanctions directly and solely related to the termination or modification of this Agreement shall be returned to the MCOP.

e. Final Accounting of Amounts Outstanding

The MCOP must submit to ODM a final accounting list of any outstanding monies owed by ODM no later than six (6) months after a termination/nonrenewal date of this

Agreement. Failure by the MCOP to submit a list of outstanding items will be deemed a forfeiture of any additional compensation due to the MCOP. ODM payment will be limited to only those amounts properly owed by ODM.

f. Data Files

In order to assist members with continuity of care, the MCOP must create data files if requested by ODM. The data files must be provided in a consistent format specified by ODM and may include information on the following: care management, prior authorizations, inpatient facility stays, PCP assignments, pregnant members and any other information as specified by ODM. The timeline for providing these files will be at the discretion of ODM. The MCOP will be responsible for ensuring the accuracy and data quality of the files.

g. Provider Notification

The MCOP must notify contracted providers within 30 days of notice from ODM of the effective date of termination or modification of this Agreement. The provider notification must be approved by ODM prior to distribution.

APPENDIX Q

PAYMENT REFORM

I. Introduction.

On January 9, 2013, Governor John Kasich's Advisory Council on Health Care Payment Reform adopted the Catalyst for Payment Reform (CPR) principles as part of a comprehensive strategy to prioritize and coordinate multi-payer health care payment innovation activities in Ohio. The Ohio Department of Medicaid (ODM) is committed to reforming the health care delivery system by designing and implementing systems of payment that signal powerful expectations for improved health care delivery. As such the following principles have been adopted by Ohio Medicaid:

1. Payment reforms should promote health by rewarding the delivery of quality, cost effective and affordable care that is patient-centered and reduces disparities.

2. Health care payments should encourage and reward patient-centered care that coordinates services across the spectrum of providers and care setting while tailoring health care service to the individuals patient's needs.

3. Payment policies should encourage alignment between public and private sectors to promote improvement, innovations and meeting national health priorities, and to maximize the impact of payment decisions of one sector on the other.

4. Decisions about payment should be made through independent processes that are guided by what serves the patient and helps society as a whole, and payment decisions must balance the perspectives of consumers, purchasers, payers, physicians and other health care providers.

5. Payment policies should foster ways to reduce expenditure on administrative processes (e.g., claims payment and adjudications).

6. Reforms to payment should balance the need for urgency against the need to have realistic goals and timelines that take into account the need to change complex systems and geographic and other variations.

In order to improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, there must be significant changes in existing payment structures and methodologies as well as the environment in which payments are made. This Appendix outlines ODM's expectations for how a MyCare Ohio Plan (MCOP) shall achieve progress in the following areas:

A. **Value-Oriented Payment:** The MCOP shall design and implement payment methodologies with its network providers that are designed either to cut waste or reflect value. For the purposes of this Provider Agreement, payments that cut waste are those that by their design reduce unnecessary payment and unnecessary care (e.g. elective cesarean deliveries). Value is defined as the level of the quality of care for the amount of money paid to the provider. Payments designed to reflect value are those that are tied to provider performance so that they may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.

B. **Market Competition and Consumerism:** The MCOP shall design contracting methodologies and payment options and administer the benefit package to members in a manner that enhances competition among providers and reduces unwarranted price and quality variation. To stimulate provider competition further, the MCOP shall establish programs to engage MCOP members to make informed choices and to select evidence-based, cost-effective care.

C. **Transparency:** The MCOP shall make available to ODM and the MCOP's members the information that members will need to understand and compare the quality, cost, patient experience, etc., among providers in the network.

These commitments are included to support and advance MCOP initiatives to develop a health care market where (a) payment increasingly is designed to improve and reflect the effectiveness and efficiency with which providers deliver care, and (b) consumers are engaged in managing their health, selecting their providers, and sensitive to the cost and quality of services they seek. The term "provider" is defined in OAC rule 5160-58-01. The MCOP must use its best efforts to ensure that these commitments and initiatives apply to the benefits offered and services provided under this Provider Agreement and administered by the MCOP.

II. Obligations of MCOP

A. VALUE-ORIENTED PAYMENT, MARKET COMPETITION & CONSUMERISM

The MCOP shall implement payment strategies that tie payment to value or reduce waste, as those terms are defined herein. In doing so, the MCOP shall make 20% of aggregate net payments to providers value-oriented by 2020. Examples of strategies include the following:

1. Paying providers differentially according to performance (and reinforce with benefit design).

2. Designing approaches to payment that cut waste while not diminishing quality, including reducing unwarranted payment variation.

3. Payments designed to encourage adherence to clinical guidelines. At a minimum, the MCOP must address policies to discourage elective deliveries before 39 weeks.

4. Payment strategies to reduce unwarranted price variation, such as reference or value pricing (e.g. analysis of price variation among network providers by procedure and service types, pilot value pricing programs, encouragement of member value-based pricing information , center of excellence pricing, and rebalance payment between primary and specialty care).

B. TRANSPARENCY

1. Quality, Efficiency and Price

The MCOP shall work to develop a strategy and work plan to report the comparative performance of providers, using the most current nationally-recognized and/or nationally–endorsed measures of hospital and physician performance. Information delivered through a provider ranking program must be meaningful to members and reflect a diverse array of provider clinical attributes and activities. At a minimum, the MCOP is expected to make information available to members regarding provider background, quality performance, patient experience, volume, efficiency, price of service, and cultural competency factors. If the MCOP determines that it is not in the best interest of members, or counterproductive to the goals set forth in this Appendix, to provide information to members regarding one or more of these elements the MCOP must document the reason(s), and submit to ODM for approval. The information should be integrated and accessible through one forum providing members with a comprehensive view. In addition, the cost of services shall be transparent and available to the consumer.

2. Consumer Tools and Incentives

Make quality, efficiency and price comparisons of providers accessible. The MCOP shall work to integrate provider information into a comprehensive display to provide members with “user friendly” support in selection of higher-value providers. Provider comparisons shall incorporate quality, efficiency and price

information among all providers for all services in all markets in which the MCOP operates. Information shall be displayed in such a way that makes relevant information both accessible and easily understood to members, regardless of search level. Information shall be available through web, mobile devices, provider directories, print and/or other consumer decision tools.

III Reporting

The MCOP must submit a quarterly progress report as specified by ODM that addresses progress towards meeting the obligations as outlined in II above.