Section 1915(b) Waiver
Proposal For
MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs

Table of Contents

Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State** of **Ohio** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is **Ohio Children in Managed Care and OhioRISE** (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

___ initial request for new waiver. All sections are filled.

_ _ amendment request for existing waiver, which modifies Section/Part ____

__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

__ Document is replaced in full, with changes highlighted

_X_ renewal request

__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

_X_ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is _X__ replaced in full

_ _ carried over from previous waiver period. The State:

_ __ assures there are no changes in the Program Description from the previous waiver period.

___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___ replaced in full

_X__ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

_X__ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for - effective date July 1, 2022 and ending June 30, 2027. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is Kelsey Hiegel and can be reached by telephone at (614)752-3613 or e-mail at Kelsey.Hiegel@medicaid.ohio.gov and for the OhioRISE program, Autumn Darnell who can be reached by telephone at (614)752-4459 or email at Autumn.Darnell@medicaid.ohio.gov. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

Response: **There are no Federally recognized tribes in the State of Ohio.**

Program History
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Background

The contract (known as the provider agreement) with the managed care organizations (MCOs) as referenced in this waiver application is available at:
https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans

Information about the new Ohio Resiliency through Integrated Systems and Excellence (OhioRISE) program is available at:
https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/

PROGRAM HISTORY

Ohio Medicaid has been contracting with managed care organizations since 1978 and has operated a mandatory enrollment program since 1989. This 1915(b) waiver amendment in part acts as a supplement to the federal state plan amendment (SPA) authority for mandatory managed care, initially approved by the Centers for Medicare and Medicaid Services (CMS) in 2005 and subsequently in 2006 for statewide Medicaid managed care expansion. Ohio currently operates its mandatory Medicaid managed care program under a SPA [for the Aged, Blind or Disabled population and the Modified Adjusted Gross Income (MAGI) formerly known as the CFC population, with limited exceptions]. As a supplement to Ohio's existing 1932(a)(1)(A) authority, effective July 1, 2013, Ohio added Supplemental Security Income (SSI) children under the age of 21 to the Medicaid managed care program under a 1915(b) waiver approved by CMS. CMS subsequently approved a 1915(b)(c) waiver, for an effective date of March 1, 2014 which allows Ohio to enroll Medicaid-Medicare duals in managed care through the Integrated Care Delivery System (ICDS) Demonstration, also known as MyCare Ohio program. The MyCare Ohio program was implemented effective May 1, 2014.

Effective August 1, 2016, Ohio amended its Medicaid eligibility methodology authority from 209(b) to 1634, including the addition of populations eligible under 1915(i) SPA and Miller Trust authorities. The April 1, 2018 1915(b) waiver renewal reflected the changes associated with the 1634 methodology and added 2 mandatory child populations to Ohio's existing managed care program effective January 1, 2017. ODM added the MAGI (formerly CFC) children population to the waiver effective January 15, 2017 upon expansion of the respite benefit.

In 2019, Ohio Medicaid launched the Medicaid Managed Care Procurement process with a new vision for Ohio's Medicaid program. ODM intends to put the individual at the center of focus and improve the design, delivery, and timeliness of care coordination. This effort depends on the collective implementation of several strategic initiatives, termed "the big 5" including, Ohio Managed Care Procurement, OhioRISE, Single Pharmacy Benefit Manager, Fiscal Intermediary, and a Provider Network Module and Centralized Credentialing. More information about the Ohio Medicaid initiatives listed above may be found at: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care

REQUEST FOR 1915 (B) WAIVER AUTHORITY RENEWAL AND AMENDMENT

This 1915(b) waiver renewal is being requested to continue the mandatory enrollment of Medicaid SSI individuals under the age of 21 years enrolled in Ohio's Medicaid managed care program, children enrolled in Title V Bureau for Children with Medical Handicaps (BCMH) and IV-E Foster Care, children in other out of home placement, and Adoption Assistance programs to Ohio's mandatory managed care program.

This 1915(b) waiver is also being amended to include a new specialized managed care program for youth with complex behavioral health and multi-system needs called OhioRISE (Resilience through Integrated Systems and Excellence). Children in Ohio with complex behavioral health needs or who are involved in multiple state systems, such as Foster Care or Juvenile Justice need a different type of care coordination in order to ensure access to the right services to meet their needs and reduce a reliance on out-of-state or residential placement. This specialized program will allow Ohio to provide the necessary focus on this population to improve health outcomes, create a comprehensive plan of care that addresses the unique child and family needs, and reduce the overall cost of care. Ohio has contracted with a Prepaid Inpatient Health Plan (PIHP) to provide behavioral health services to children who meet the threshold score on a Child and Adolescent Needs and Strengths (CANS) assessment, or other needs assessment performed.

The 1915(b) waiver will run concurrently with a new 1915(c) home and community based services waiver targeting children who meet an inpatient psychiatric hospital level of care, diagnosis of Serious Emotional Disturbance (SED) and are at risk of custody relinquishment because of their specialized behavioral health needs.

Per federal regulations, mandatory exempt groups identified in Section 1932(a)(1)(A)(i) of the Social Security Act and 42 CFR 438.50 are not required to enroll in a mandatory managed care program unless CMS has granted the state 1915(b) or 1115 waiver authority to enroll the mandatory exempt group. Additionally, a Section 1932(a) state plan amendment cannot be used to authorize a managed care program requiring mandatory enrollment into a PIHP. In adding SSI, Title V and IV-E enrolled children to the mandatory managed care program as permitted by ORC 5167.03 and including a new delivery system for children with complex behavioral health issues, Ohio Medicaid has assessed managed care program objectives and affirmed the system designed meets the future goals of the program. Those objectives include:

- **improve wellness & health outcomes**
- **emphasize a personalized care experience**
- **support providers in better patient care**
- **improve care for children & adults with complex needs**
- **increase program transparency & accountability**

MANAGED CARE EXPERIENCE

The Office of Managed Care in the Ohio Department of Medicaid (ODM) is responsible for managed care policy and program development, contract administration and serves as the primary contact with the MCOs. The ODM Strategic Initiatives Office will oversee the OhioRISE plan contract and policy. Other areas within ODM oversee additional managed care functions such as, quality oversight, clinical, financial performance, and assessment and monitoring. The expansion of the program and subsequent operational challenges have resulted in increasing administrative sophistication in virtually all areas of program operation. ODM will leverage the successful processes for the next generation managed care program, including OhioRISE, in the following areas:

- **Rate-setting: Ohio Medicaid contracts with an independent actuary to set actuarially sound capitation rates.**

- **Access: Ohio Medicaid sets specific minimum provider panel requirements, especially in the area of primary care capacity and provider location, and the use of a database to track this information to enhance accountability. ODM is also moving to a centralized credentialing process to reduce administrative burden for providers having to credential with multiple MCOs. Additionally, ODM has implemented standard databases for appeals/ grievances, provider and consumer complaints and utilization management performance. The standard databases decrease reporting variations among MCOs and enhance access monitoring by ODM.**

- **Quality: Each year, MCOs (and soon the OhioRISE plan) are required to develop a description of their Quality Assessment and Performance Improvement (QAPI) program, reflecting a systematic approach for assessing and improving the quality of care and health outcomes for members. The components of the QAPI program include performance improvement projects (PIPs), assessment of health care service utilization, assessment of quality and appropriateness of care for consumers with special health care needs, submission of performance measurement data, a plan to address health disparities, and an assessment of the impact and effectiveness of the QAPI program. Ohio Medicaid's contracted external quality review organization (EQRO) performs both mandatory and optional EQRO activities. Mandatory EQRO activities include validation of performance improvement projects, validation of performance measures, administrative compliance assessment, and validation of network adequacy. Optional EQRO activities include validation of encounter data studies, consumer surveys, provider surveys, information systems reviews, calculation of program evaluation/clinical performance measures, implementation of PIPs, and rating of managed care plans/Quality Rating System (contingent on CMS protocol development).**

- **Consumer protections: Requirements for MCO grievance systems, member education, and member services, as well as the requirement for a statewide 1-800 number and access to the state fair hearing process, are safeguards to ensure access and quality care for members. ODM requires an independent Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey annually.**

- **Utilization: All MCOs and the OhioRISE plan are required to submit encounter data to ODM. ODM has performance standards for several performance areas including prenatal care and care for children with new measures added for the OhioRISE program.**

- **Overall performance: MCOs are required to meet minimum enrollment levels and are subject to financial and non-financial penalties depending on the severity of the compliance action. ODM's compliance assessment system outlines remedial actions associated with MCO and OhioRISE Plan noncompliance with program requirements, including those related to access and quality of services. Types of sanctions and remedial actions include the following: corrective action plans (CAPs), financial sanctions, new member enrollment freezes, and reductions in assignments. Additionally, there must be evidence that immediate and appropriate actions are taken to correct the problem and prevent recurrence. ODM reviews repeated incidents and determines whether the MCO or OhioRISE Plan has a systemic problem. Further sanctions or remedial actions may be assessed against the MCO or OhioRISE Plan if ODM determines that a systemic problem exists.**

- **Community involvement: ODM convenes community-based meetings with key stakeholders to ensure ongoing public involvement.**
  Ohio has a mature Medicaid managed care program with robust requirements for the MCOs. The MCOs currently serve over 3 million members statewide. This includes roughly 143,000 Medicaid/Medicare duals who are enrolled in MyCare Ohio plans under the MyCare Ohio program.

  Stakeholder and community involvement are vital to the success of Ohio's Medicaid managed care program. The MCOs and the OhioRISE plan are required to hold member and provider councils to ensure sufficient stakeholder involvement at every level of the program. MCOs will also be required to work closely with community-based organizations to address the care coordination and social determinants of health needs of their membership. ODM involves stakeholders in policy and program development decisions as described in more detail on page 11.

COMMUNITY AND STAKEHOLDER INVOLVEMENT

The Ohio Medicaid managed care program has consistently sought to involve interested parties in the development and operational activities pertaining to managed care. Advisory Councils were developed to include local providers, consumers and advocates, managed care organizations, county departments of job and family services, local health departments, and other social service agencies. The ODM-lead Medical Care Advisory Committee has served as a forum for discussion of the managed care program and related issues.

In addition to these groups, ODM has used ad hoc "roundtables" for the discussion of specific issues such as dental access, pharmacy initiatives , behavioral health redesign, transition of SSI children to Medicaid managed care etc.

With the transition to the new generation of Medicaid managed care through the "big 5" initiatives, ODM has continued our robust stakeholder engagement efforts. We are working collaboratively with other state agencies such as Ohio Department of Job and Family Services (ODJFS), County Departments of Job and Family Services (CDJFS), Mental Health Addiction Services (MHAS), Department of Developmental Disabilities (DODD), Department of Youth Services (DYS), Ohio Department of Education (ODE), and Ohio Department of Aging (ODA) to keep the focus of the redesigned program on the individual with the goal of providing a seamless experience for members and providers. ODM has an open and transparent process during the redesign offering education and outreach to those interested. Staff traveled across the state to meet with providers, consumers, and community partners as part of the redesigned managed care program development. Insight gleaned from this stakeholder engagement was incorporated into the new program design.

Ohio continues to work with health care providers and stakeholders through meetings, webinars, technical assistance trainings and other forums. Stakeholders include, but are not limited to:

- **National Alliance on Mental Illness of Ohio**
- **Ohio Association of Health Plans**
- **Ohio Association of County Boards Serving People with Developmental Disabilities**
- **Bureau for Children with Medical Handicaps (BCMH)**
- **Ohio Family & Children First Councils**
- **County Public Children Services Agencies**
- **Ohio Council for Home Care & Hospice**
- **Child and Family Health Collaborative of Ohio**
- **Ohio Children's Hospital Association**
- **Ohio Dental Association**
- **Ohio Legal Aid**
- **Ohio Hospital Association**
- **The Center for Community Solutions**
- **The Ohio Council for Behavioral Health & Family Providers**
- **Ohio Autism Insurance Coalition**
- **Ohio Center for Autism and Low Incidence**
- **The Buckeye Ranch**
- **New Directions and Crossroads Health**
- **Mercy Health**
- **Foundations Behavioral Health Services**
- **Centers for Innovative Practices, Case Western Reserve University**

Community and outreach activities conducted by MCOs have focused on consumers, parents, guardians, providers, community support organizations, and advocacy groups. Examples include:

- **Attempting to contact all households to complete a health risk assessment.**
- **Mailing introductory and/or open enrollment letters, welcome kits, welcome cards, member handbooks, health and wellness materials, medical questionnaires, and consumer surveys.**
- **Hosting community-based forums.**
- **Inviting children and families to participate in the MCO's Advisory Council.**
- **Holding consumer focus groups to elicit consumer input and identify barriers to care.**
- **Utilizing member incentives to encourage member engagement.**

Examples of ODM outreach activities conducted to educate stakeholders about OhioRISE includes:

- **Creation of an OhioRISE Advisory Council and associated workgroups to obtain critical stakeholder feedback and expert clinical advice for OhioRISE's services and operations. Since the Council's creation in January 2021, ODM has held 30 separate meetings with stakeholders to discuss general program principles and system of care philosophy. The new and enhanced state plan behavioral health services, specifications and regulatory concepts, and draft rule language have been discussed. The OhioRISE 1915(c) waiver program, including eligibility, waiver service and provider specifications, and critical incident reporting have also been topics.**
  In the coming months, the Advisory Council will form an "Implementation and Operations" workgroup to plan for implementation of the OhioRISE PIHP and waiver.
- **The OhioRISE plan and ODM are in the process of providing presentations to a broad range of stakeholder groups, including providers, provider associations, consumer advocacy organizations, local/county public agencies (children's services agencies, county boards of developmental disabilities boards, mental health and addiction services boards, family and children first councils, school districts, local public health agencies) to provide information about the program, its benefits for consumers, referral pathways, and ongoing topics related to implementation. These meetings and presentations will be used to increase awareness of the program and the transition of children into the program, and to establish or strengthen relationships that will be critical to successfully implementing the program. These outreach activities will continue through the July 1, 2022 implementation, and beyond as needed.**

Additional outreach conducted by the OhioRISE plan and/or ODM will include:

- **Information in community outreach newsletters focused on educating community partners.**
- **Inviting new community partner organizations to member and family advisory council meetings.**
- **Attending conferences focused on the unique needs of waiver children and their families.**
- **Hosting a series of meetings with legislators to introduce the OhioRISE plan and offer support on constituent inquiries involving enrolled children.**
- **Participating with other MCOs and advocacy organizations in workgroup meetings facilitated by ODM to develop enrollment materials and update marketing materials to include children enrolled in OhioRISE.**
- **Volunteering in community events held by organizations serving children with complex needs.**

At the time Ohio added respite services for Medicaid SSI children under 1915(b)(3) waiver authority, ODM sought informal and formal stakeholder input. Ohio conducted several meetings and solicited input from stakeholders and beneficiary advocacy groups including the Ohio Respite Coalition, Ohio Council for Home Care and Hospice, Midwest Care Alliance, Voices for Children and Medicaid MCOs. Ohio received broad support from its stakeholders who include the families and representatives of the children as well as the key providers who serve children in Ohio. The State will leverage the savings from the 1915(b) waiver to provide respite services that are easy to navigate, person-centered and cost-effective. Providing respite services reaches those beneficiaries with the greatest need for services, and potentially reduces the overall cost of care. With the implementation of OhioRISE, ODM is working with stakeholders again to update the behavioral health respite benefit for OhioRISE members.

This waiver was posted for public comment along with the OhioRISE 1915(c) waiver in June 2021.

CONCLUSION

The Ohio Medicaid program has successfully transitioned SSI children from the fee-for-service system to mandatory managed care through the 1915(b) waiver application, beginning July 1, 2013 and through the recent renewal which was approved by CMS effective through March 31, 2022. The managed care program's previous experience under the SPA and previous waivers and the successful implementation of statewide mandatory managed care supported the request to amend the 1915(b) waiver that was approved from July 1, 2015 – March 31, 2018 adding the Title V BCMH and IV-E foster care and adoption assistance populations and continuing the 1915(b) waiver authority for Ohio's Special Needs Children's

Waiver. Ohio successfully enrolled the new populations beginning January 1, 2017 and continues to enroll eligible Medicaid recipients on an ongoing basis, providing coordination of care and care management opportunities to enrollees. As part of the renewal, beginning July 1, 2018, Ohio included behavioral health services that were carved out of the managed care benefit.

The managed care program's experience under the SPA and waivers and successful enrollment of new populations supports the request to renew and amend our 1915(b) waiver for an additional five years to continue providing Ohio's Medicaid recipients with quality care and improved health outcomes in a newly redesigned system that incorporates the overall goals for the health and wellness of the Ohio Medicaid population and the specific behavioral health needs of OhioRISE members.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a._ X__ **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. __ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. _X_ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. _X_ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

_X_ MCO **for the Medicaid managed care program**
_X_ PIHP **for the OhioRISE mandatory managed care program**
___ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
___ FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a.___ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

b._X__ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
Ohio Medicaid managed care program and OhioRISE

c._X_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
Ohio Medicaid managed care program and OhioRISE

d._X_ **Section 1902(a)(4) -** To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
All Medicaid members who meet the criteria for OhioRISE eligibility will be enrolled in a single OhioRISE plan. ODM will require the OhioRISE plan to offer choice of providers for each service level.

e.___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a._X__ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b.**_X__ PIHP:** Prepaid Inpatient Health Plan means an entity that:
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

_X_ The PIHP is paid on a risk basis **for all behavioral health services.**
___ The PIHP is paid on a non-risk basis.

c.___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3)
does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

d.___ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ___ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f.___ **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement**. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

_X__ **Competitive** procurement process **for MCOs and OhioRISE plan** (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

___ **Open** cooperative procurement process (in which any qualifying contractor may participate)

___ **Sole source** procurement

___ **Other** (please describe)

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. **Assurances.**

_X__ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

All MCO enrollees will be given choice of at least two plans.

_X__ The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

The single OhioRISE plan will specialize in children and adolescents who have complex behavioral health needs. ODM requires the single OhioRISE plan to provide choice of services covered under the contract and the OhioRISE plan will help facilitate access to necessary services through a care planning process.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

_X__ Two or more MCOs **for the Medicaid managed care program.**
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
_X__ Other:(please describe) **OhioRISE enrollees will have choice of provider.**

3. **Rural Exception.**

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting**

___ Beneficiaries will be limited to a single provider in their service area (please define service area).
___ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

_X__ **Statewide** -- all counties, zip codes, or regions of the State

___ **Less than Statewide**

2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	**MCO**	**United Healthcare Community Plan of Ohio, Humana Health Plan of Ohio, Molina Healthcare of Ohio, AmeriHealth Caritas, Anthem Blue Cross and Blue Shield, CareSource Ohio, and Buckeye Community Health Plan**
Statewide	**PIHP**	**Aetna Better Health of Ohio**

E. Populations Included in Waiver-

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations**. The following populations are included in the Waiver Program:

_X_ Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

_X__ Mandatory enrollment **Medicaid managed care program [for MAGI (formerly CFC) children under the age of 21 and MAGI children under age 21 who are eligible for Supplemental Security Income (SSI) under Title XVI and Title V BCMH enrollees.]**
OhioRISE [anyone under the age of 21 who meets the threshold score on the CANS or other assessment or is admitted as an inpatient for a behavioral health diagnosis]

___ Voluntary enrollment

_X_ Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

_X__ Mandatory enrollment **OhioRISE [for members who are inpatient at a Psychiatric Residential Treatment Facility or receiving inpatient hospital psychiatric services on their 21st birthday and are enrolled in OhioRISE will continue to stay enrolled in OhioRISE until they are discharged or turn 22]**

___ Voluntary enrollment

_X__ Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

_X__ Mandatory enrollment **OhioRISE [for members who are inpatient at a Psychiatric Residential Treatment Facility or receiving inpatient hospital psychiatric services on their 21st birthday and are enrolled in OhioRISE will continue to stay enrolled in OhioRISE until they are discharged or turn 22]**

___ Voluntary enrollment

_X__ Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

_X__ Mandatory enrollment **Medicaid managed care program [for ABD children under the age of 21 who are eligible for Supplemental Security Income (SSI) under Title XVI]**

OhioRISE [anyone under the age of 21 who meets the threshold score on the CANS or other assessment or is admitted as an inpatient for a behavioral health diagnosis]

___ Voluntary enrollment

___ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

___ Mandatory enrollment
___ Voluntary enrollment

_X__ Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

_X__ Mandatory enrollment **Medicaid managed care program [all are mandatory] OhioRISE [anyone under the age of 21 who meets the threshold score on the CANS or other assessment or is admitted as an inpatient for a behavioral health diagnosis]**

___ Voluntary enrollment

_X__ TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

_X__ Mandatory enrollment **Medicaid managed care program [all are mandatory]. OhioRISE [anyone under the age of 21 who meets the threshold score on the CANS or other assessment or is admitted as an inpatient for a behavioral health diagnosis]**

___ Voluntary enrollment

All children who are enrolled into the Ohio Medicaid program through the OhioRISE 1915(c) waiver will be mandatorily enrolled into the MCO for their physical health services and will be mandatorily enrolled into OhioRISE for their 1915(c) home and community-based services and their behavioral health services.

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

__X_**Medicare Dual Eligible--**Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E)) **Excluded from the Medicaid managed care program. A dual eligible individual who meets the threshold score on the CANS or other assessment or is admitted as an inpatient for a behavioral health diagnosis will be enrolled in OhioRISE unless the individual is enrolled in a MyCare Ohio Plan.**

___ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

___ **Other Insurance--**Medicaid beneficiaries who have other health insurance.

__X_**Reside in Nursing Facility or ICF/MR--**Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR). **Excluded only from the Medicaid managed care program. Any member under 21 who meets the threshold score on the CANS or other assessment or is admitted as an inpatient for a behavioral health diagnosis will be enrolled in OhioRISE.**

___ **Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program

___ **Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

___ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver)

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

__ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

___ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

_X__ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

_ __ **Other** (Please define):

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

_X__ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

_X__ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC

- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

_X__ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

Access to services rendered in an emergency room will be provided through MCOs and will not be included in the benefits offered through OhioRISE.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

_X__ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

___ The State will pay for all family planning services, whether provided by network or out-of-network providers.

___ Other (please explain):

_X__ Family planning services are not included under the waiver.

Access to family planning services will be provided through MCOs and will not be included in the benefits offered through OhioRISE.

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

___ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside

the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

_X__The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program. MCO is required to reimburse out-of-network FQHC services.
MCOs must cover FQHC services regardless of network status. OhioRISE will pay for behavioral health services provided by an FQHC to OhioRISE members regardless of network status.

5. **EPSDT Requirements.**

_X__The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

_X_This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

Service: **"Respite services" are services that provide short-term, temporary relief to the informal, unpaid primary caregiver of an individual under the age of 21 to support and preserve the primary caregiving relationship. Respite services can be provided on a planned or emergency basis. The respite service is available statewide and is comprised of a long-term services and supports (LTSS) respite and a behavioral health (BH) respite. The MCOs will cover LTSS respite and the OhioRISE plan will cover BH respite. Total expenditures by the MCOs and the OhioRISE Plan on respite services cannot exceed the total annual resources available for the respite program.**

LTSS Respite will be available to MCO members who are participating in a care management arrangement and their caregivers. Additional eligibility criteria include, being assessed for an institutional level of care, a need for fourteen hours of home health aide services, or a need for skilled nursing or skilled rehabilitation services once per week. The child must be determined eligible for social security income for children with disabilities or supplemental security income. The LTSS respite will be prior authorized by the MCO and the MCO must have determined that the member's primary caregiver has a need for temporary relief from the care of the member as a result of the member's LTSS needs, or in order to prevent an inpatient, institutional or out-of-home stay. The MCOs will provide the respite service under a separate capitated rate up to the financial limits of this 1915(b) waiver.

BH Respite will be available to all OhioRISE enrolled members who reside with his or her primary caregiver(s) in a home that is not owned, leased, or controlled by a provider of any health-related treatment or support services. The OhioRISE member must have behavioral health needs for the BH respite service as determined by the OhioRISE Plan. The BH respite will be prior authorized by the OhioRISE Plan; services will be authorized in an amount and duration consistent with the member's needs and behavioral health history. The OhioRISE Plan will cover BH respite when there is a determination that the member's primary caregiver(s) have a demonstrated need for temporary relief from the care of the member as a result of the member's behavioral health needs. The OhioRISE Plan will provide the BH respite service under a separate capitated rate up to the financial limits of the 1915(b) waiver.

Eligible providers of the MCO covered LTSS respite service must comply with the criminal records check requirement set forth in rules 5160-45-07 and 5160-45-11 of the Administrative Code. Service providers must be, either:

- **Medicare-certified home health agencies pursuant to Chapter 3701-60 of the Ohio Administrative Code, or**
- **Otherwise-accredited agencies (i.e., accredited by the Joint Commission, the Community Health Accreditation Program, or the Accreditation Commission for Health Care**

All eligible LTSS respite providers will obtain a certificate of completion of either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health under section 3721.31 of the Ohio Revised Code, or the Medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.36, and obtain and maintain first aid certification.

Eligible providers of the OhioRISE covered BH respite service providers must be one of the following:

- **Individuals employed by Ohio Mental Health and Addiction (MHAS)-certified and Medicaid enrolled agency providers pursuant to 5160-27-01 of the Ohio Administrative Code.**
- **Department of Developmental Disabilities certified providers of informal respite in accordance with 5123-9-21 of the Ohio Administrative Code.**
- **Department of Developmental Disabilities certified providers of community respite in accordance with 5123-9-22 of the Ohio Administrative Code.**
- **Family as defined in rule 5160-59-01 of the Administrative Code, who do not also meet the definition of legally responsible family member as defined in rule 5160-45-01 of the Administrative Code, and who do not reside in the home with the member.**
- **Natural supports as defined in 5160-59-01 of the Ohio Administrative Code.**

Eligible BH respite providers meeting the qualifications as defined above must also comply with the criminal records check requirements set forth in 5160-43-09 of the Ohio Administrative Code. All eligible providers will also obtain and maintain first aid certification and will complete trauma-informed care practices as set forth in rule 5101:2-9-42 of the Ohio Administrative Code.

Service: **Primary Flex Funds are services, equipment, or supplies not otherwise provided through the Medicaid state plan or the OhioRISE program that addresses an individual's identified need. They are intended to enhance and supplement the array of services available to the individual enrolled in the OhioRISE program along with improve and maintain the OhioRISE member's opportunities for full community participation. Primary Flex Funds meet the following requirements:**

- **The purchased item/service decreases the need for other Medicaid services; and/or**
- **Promotes the individual's inclusion in the community; and/or**
- **Increases the individual's safety in the home environment.**

In order to access Primary Flex Funds, the individual must not have the ability to purchase the service or item through other available funds or via another source. Goods or services provided by a Medicaid Agreement holder must first be submitted to the OhioRISE Plan for consideration under the Early Periodic Screening and Diagnostic Treatment criteria. Primary Flex Funds are additive to, and do not duplicate, what is available to an individual under the Medicaid State Plan benefit.

The Primary Flex Funds service cannot be used to pay for:

- **Experimental treatments;**
- **Items used solely for entertainment or recreational purposes;**
- **Tobacco or alcoholic products;**
- **Items of the same type for the same individual unless there is a documented change in the individual's condition that warrants replacement;**
- **Home modifications that are of general utility or that add to the total square footage of the home;**
- **Items or treatments that are illegal or otherwise prohibited through federal or state regulations;**
- **The costs of room and board.**

An OhioRISE plan member is limited to $1,500 for Primary Flex Funds within 365 days.

Primary Flex Funds will be provided statewide and available only to OhioRISE enrollees. Reimbursement: The MCOs and OhioRISE plan will provide Respite and Primary Flex Funds under a separate capitated rate up to the financial limits of this 1915(b) waiver.

7. **Self-referrals.**

_X__The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

FQHC/RHC services for MCOs and OhioRISE

Title X services provided by any qualified family planning provider (QFPP)

Any women's health specialist within the MCO's network for covered care necessary to provide women's routine and preventive health care services.

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

_X__ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

__X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

b. **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

c. **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

B. Capacity Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

_X__ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a.___ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b.___ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.

c.___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d.___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

*Please note any limitations to the data in the chart above here:

e.___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f.___ **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	*PCCM-to-Enrollee Ratio*
Statewide Average: (e.g. 1:500 and 1:1,000)	

g. ___ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

1. **Assurances For MCO, PIHP, or PAHP programs.**

_X__ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs**.

The following items are required.

a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

b. _X_ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

To ensure all individuals have access to quality care coordination, ODM initiated changes to the care management strategy to focus on a continuum of care coordination and deliberate support for already existing care coordination entities (CCEs) in the community.

With continued efforts to address physical, behavioral and psychosocial needs through a person-centered, trauma-informed approach, the MCOs will additionally focus on preserving and leveraging existing relationships between individuals and community CCEs, establish clear communication and delineation of roles, and implement systems capable of efficiently exchanging data to effectively coordinate care. This shift allows the MCO to tailor care coordination activities and staff to the individual's needs ranging from short-term assistance to meet care gaps to longer-

term, intensive, and holistic care management for individuals with the most intense needs.

MCOs are required to evaluate multiple factors (e.g., risk stratification, CCE involvement, etc.) to determine the level of care coordination appropriate for each individual. The MCO must develop a risk stratification framework as part of its care coordination program comprised of three tiers (lowest to highest risk). The MCO's criteria and thresholds for risk tiering must include acuity of chronic conditions, substance use and/or mental health disorders, maternal risk, inpatient or emergency department utilization, social determinants of health, and safety risk factors. MCOs must use multiple data inputs as part of their risk stratification methodology, such as, claims data from ODM, physician reported information, and information gathered during the completion of the standardized Health Risk Assessment (HRA) required for all members.

All members enrolled into OhioRISE are considered individuals with special health care needs based on their complex behavioral health needs. Identification of these members is done through referral to the CANS or other assessment or based on an inpatient admission for a behavioral health condition. MCOs, providers, and members are all able to make referrals to the CANS to determine if the member meets the threshold score for OhioRISE enrollment.

c. _X_ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

In 2019, MCOs began using an ODM-standardized Health Risk Assessment for all newly enrolled members. In 2020, the MCOs expanded the use of the HRA to their entire membership. The HRA identifies immediate needs as well as informs the risk stratification and care coordination needs.

The MCOs must arrange for additional assessments (e.g., comprehensive assessment, disease specific assessment, CANS assessment) specific to the individual's unique needs and circumstances. The type of assessment varies based on the individual's risk tier and unique needs and circumstances. The MCO must make efforts to minimize and prevent duplication in conducting assessments by using all other available sources of data to inform the assessment process. The MCO must share the assessment results and identified needs, as appropriate, to prevent duplication of those activities. The individual, family, and providers must have opportunity to participate in the assessment process.

Assessments must be updated when there is a change in the member's health status or needs, a significant health care event, a change in diagnosis, or as requested by

the individual or provider. The MCO must have a process to address how it will handle beneficiaries who cannot be reached or who refuse assessments. The MCO uses the assessment to identify needs, confirm the risk level for each individual and develop and update the person-centered care plan when appropriate.

The MCO is responsible for ensuring that staff participating in all parts of the care management process are operating within their scope of practice, appropriate for the individual's health care needs, and follow state's licensure/credentialing requirements.

All OhioRISE members must receive a Child and Adolescent Needs and Strengths (CANS) assessment either prior to enrollment or immediately upon enrollment to determine individual strengths and needs. The results of this assessment are used to help inform the child and family-centered care planning process to develop a care plan specific to the needs of the member and their family. Information from the MCO health risk assessment or other assessments must be collected by the OhioRISE plan and integrated into their system to ensure the child and family-centered care plan addresses all the needs of the member. At any point there is a change in member circumstance the OhioRISE plan must facilitate a timely CANS assessment, performed by an independent organization or practitioner external to the OhioRISE plan for Tier 1 members or by the Care Management Entity for other care coordination tiers.

OhioRISE members may self-refer to receive a CANS assessment at any time, and the MCOs and OhioRISE plan is prohibited from requiring prior authorization for this service.

Based on the CANS assessment and other information from the MCO or service providers, and identified social determinants of health risk factors, members are assigned a specific tier of care coordination consistent to their level of needed support.

d. X **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1.X_ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

MCOs must ensure that a person-centered care plan is developed for members based on the most recent assessment. Person-centered care plans must include prioritized goals, interventions, and anticipated outcomes. Goals must be developed with, and should be agreed to by, the member and documented in the person-centered care plan. Care plan goals should be congruous with

needs identified by the primary care provider. The care planning process will include a provision to update the care plan as needs change and/or to address any gaps in care. The MCO will make the person-centered care plan available to members of the care team. A communication plan with the member will be established and documented in the care management record.

The MCO must assign an accountable point of contact (i.e., care manager) to each individual based on need and preference. The MCO must respect, promote and support care coordination provided within the community and is encouraged to use a team approach to manage the individual's needs. The MCO is responsible for ensuring that the staff participating in all parts of care management process including the development of the person-centered care plan are operating within their professional scope of practice while following the state's licensure/credentialing requirements and are responding to the member's health care needs.

All OhioRISE members must have a child and family-centered care plan that documents all necessary services and supports and is consistent with System of Care Principles and High Fidelity Wraparound practice when used. Members may receive a child and family-centered service plan either from the Care Management Entity (CME) or the OhioRISE plan depending on the care coordination tier they are assigned to. Child and family-centered care plans developed by the CME are reviewed by the OhioRISE plan to determine each care plan meets ODM requirements.

2._X_ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

MCOs are required to timely identify, assess, and develop a person-centered care plan for members with complex needs. The MCO must validate that the individual received the services in the person-centered care plan, or if services were not received, taking necessary action to address and close gaps in care.

All child and family-centered care plans are reviewed by the OhioRISE plan to ensure they meet ODM requirements. The review of care plans developed by the CME and OhioRISE care coordinators also includes a review to determine the timeliness of development.

3._X_ In accord with any applicable State quality assurance and utilization review standards.

ODM will use a wide range of quality assurance standards in place to evaluate MCO performance as it relates to care management. ODM will arrange for the external quality review organization (EQRO) to conduct administrative

reviews of MCOs' compliance which includes a review the MCOs' care management program. ODM will also conduct a Care Coordination Survey to evaluate a member's experience with care coordination services. Results from the survey provide valuable information that the MCO can use to improve their care coordination program. All of these activities ensure that the MCO is meeting state quality assurance and utilization review standards and continuously improving their care coordination program.

All child and family-centered care plans are reviewed by the OhioRISE plan to ensure they meet ODM requirements, including quality assurance and utilization review standards.

e. __X_ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

MCOs must ensure that a member has direct access to a specialist appropriate for a member's condition and health care needs.

All OhioRISE members will have a child and family-centered care plan that documents necessary supports and services. The OhioRISE plan must coordinate service authorizations with the care plan process to ensure direct access to specialists.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

a. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. ___ Each enrollee is received **health education/promotion** information. Please explain.

d. ___ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. ___ There is appropriate and confidential **exchange of information** among providers.

f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ___ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

i. ___ **Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**.

_X__ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

_X__ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on _ **The Medicaid Managed Care Quality Strategy (Quality Strategy) was revised June 26, 2018 and submitted for CMS review. It can be found here: https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/MCQ-Strategy2018.pdf. The Quality Strategy is currently being updated to include new program requirements and will be submitted to CMS by December 31, 2021.**

_X__ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	**Island Peer Review Organization**		**-Validation of Performance Improvement Projects -Validation of Performance Measures -Administrative compliance assessment -Validation of network adequacy**	**-Validation of encounter data studies -Consumer surveys (CAHPS,) - Provider Surveys -Information Systems Reviews -Calculation of program evaluation/ clinical performance measures - Rating of managed care plans**
PIHP	**Island Peer Review Organization**		**-Validation of Performance Improvement Projects -Validation of Performance Measures -Administrative compliance assessment -Validation of network adequacy**	**-Validation of encounter data studies -Consumer surveys (CAHPS,) - Provider Surveys -Information Systems Reviews -Calculation of program evaluation/ clinical performance measures - Rating of managed care plans**

2. **Assurances For PAHP program.**

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. ___ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1.___ Provide education and informal mailings to beneficiaries and PCCMs;

2.___ Initiate telephone and/or mail inquiries and follow-up;

3.___ Request PCCM's response to identified problems;

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

6.___ Refer to State's medical staff for investigation;

7.___ Institute corrective action plans and follow-up;

8.___ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

12.___ Transfer some or all assignments to different PCCMs;

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ___ Initial credentialing

B. ___ Performance measures, including those obtained through the following (check all that apply):

___ The utilization management system.
___ The complaint and appeals system.
___ Enrollee surveys.
___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

d. ___ **Other quality standards** (please describe):

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. **Assurances**

_X_ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**

a. **Scope of Marketing**

1.___ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2.__X_ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

Examples of indirect marketing permitted by ODM include: radio and television advertising, billboards, bus and bench ads, informational displays, and distribution of fliers advertising events such as health fairs and trade conferences.

3.__X_The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

ODM permits MCOs to send mailings to potential enrollees upon ODM approval. ODM sends the mailing labels directly to the mailing vendor and the MCO address cannot be used as the return address in order to safeguard client confidentiality. ODM only permits MCOs to make person-to-person marketing presentations when they have been requested by the Medicaid recipient. MCOs are also permitted to participate in health fairs and other such promotional events although person-to-person interactions are still only allowed at the recipient's request. ODM uses an impartial enrollment contractor to assist recipients in the enrollment process and the MCOs do not play a role in the actual enrollment application process. MCO staff are prohibited from offering eligible individuals the use of portable devices to assist with completion of an online application to select and/or change MCOs.

The OhioRISE plan is prohibited from direct marketing to Medicaid members. Communication will be allowed with Medicaid members who are referred to it for evaluation of enrollment into the OhioRISE Plan or who are already enrolled into the OhioRISE Plan.

b. **Description**. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1._X__The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

MCOs cannot offer material or financial gain as an inducement to enroll. MCOs can provide nominal gifts. ODM limits the value to $15 so long as these gifts are prior-approved by ODM and offered whether or not the eligible individual enrolls in the MCO. ODM prior approves all marketing plans and materials and reviews all complaints and grievances for instances of noncompliance.

2.__X_The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

All marketing representatives must be employees of the MCO and duly trained and licensed by ODI. No more than 50% of a marketing representative's total annual compensation may be paid on a commission basis. ODM reserves the right to review all compensation packages for marketing representatives as its assurance of compliance with this requirement. MCOs do not play a role in the actual enrollment application process. MCO staff are prohibited from offering eligible individuals the use of portable devices to assist with completion of an online application to select and/or change MCOs. ODM reviews all complaints and grievances for instances of noncompliance.

3.__X_The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii._ _ The languages comprise all languages in the service area spoken by approximately _ percent or more of the population.

iii._X_ Other (please explain):

ODM analyzes the number of non-English speaking recipients by region and requires translation of marketing materials into any language that is >5% or more of the managed care plan's service area. Currently ODM does not have any of the following regions that have met with 5% or more threshold; therefore, Central/Southeast, Northwest and the West regions do not require translations unless requested.

The ODM managed care enrollment center (Ohio Medicaid Consumer Hotline) provides needed translation services, and the enrollment staff are able to assist all enrollees in making an MCO selection.

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

_X__ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.**

a. **Non-English Languages**

__X_ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

The State defines prevalent non-English languages as: (check any that apply):

1._X__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

>5% or more of the managed care plan's service area. MCOs and the OhioRISE plan must translate their marketing materials into the prevalent common non-English languages. Currently ODM does not have any of the following regions that have met with 5% or more threshold; therefore, Central/Southeast, Northwest and the West regions do not

require translations unless requested. ODM has identified the following languages for each region:

-Central/Southeast – Spanish and Somali
-Northeast – Spanish
-West - Spanish

If any of the plans meet the 5% threshold, they will be required to translate the following documents in the specific languages:

-Solicitation Brochures
-Transportation Brochures
-Mailed Materials
-Handouts such as brochures, fliers, announcements (excluding nominal gifts)

2. __ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.
3.__ Other (please explain):

_X__ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

MCOs, the OhioRISE plan, and the Ohio Medicaid Consumer Hotline assure access to oral translation services through the use of language line services and interpreters. Language line services are available 24 hours a day, 7 days a week.

__X_ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

The state as well as its enrollment contractor provides factual and unbiased information regarding available managed care organizations (MCOs) and the OhioRISE plan to enrollees and potential enrollees. Every eligible enrollee is provided the basic information about managed care and enrollee rights and protections as required in 42 CFR 438.10. MCOs and the OhioRISE plan are required upon enrollment to provide the enrollee with a new member letter, provider directory (via website or printed), a member handbook which includes information on EPSDT and advance directives. Frequently, MCOs distribute newsletters and health care materials to their enrollees to help them understand managed care. MCOs and the OhioRISE plan are also required to operate a toll-free member services telephone number to assist enrollees and potential enrollees seeking information about MCO or OhioRISE plan membership with information on accessing Medicaid-covered services, obtaining or understanding information about the MCO's or OhioRISE plan's policies or procedures, understanding the requirements and benefits of the plan, resolution of concerns, questions and

problems, filing of grievances and appeals, information on state hearing rights, accessing sign language, oral interpretation and translation services at no cost to the member. Potential enrollees and enrollees can also call, e-mail or write to the state or Ohio Medicaid Consumer Hotline with questions and concerns about managed care.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_X__ State
_X__ contractor (please specify) **Automated Health Systems, Inc.**

___ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)
ODM does directly enroll members into the OhioRISE plan, but because members need to either be admitted as an inpatient for behavioral health or meet the threshold score on the CANS assessment, members may be considered potential enrollees and are able to get information on the program from the state or enrollment broker.

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) _X_ the State
(ii) _X__ State contractor (please specify)**: Automated Health Systems, Inc.**
(ii) __X_ MCO/PIHP/PAHP/PCCM/FFS selective contracting provider: **MCO and OhioRISE plan**

C. Enrollment and Disenrollment

1. **Assurances.**

_X__ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

The state continues to meet these requirements for MCOs.

_X__ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

The state requests a waiver of 1932(a)(4) and 42 CFR 438.56(a) and (c) for OhioRISE members. Members are mandatorily enrolled into the OhioRISE plan if they meet the criteria for enrollment and are disenrolled when they either age out or no longer meet the threshold score on the CANS or other assessment. Only the state is permitted to disenroll members from OhioRISE.

__X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. _X__ Outreach. The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

Prior to the introduction of managed care in a new region:
The State partners with stakeholders and interested parties in the region to discuss the introduction of managed care, and to begin a dialogue among the State, the

managed care organization(s), the managed care enrollment entity (Ohio Medicaid Consumer Hotline), local social services agencies, interested community stakeholders and representatives of the beneficiary and provider community.

The State alerts MCO enrollment eligibles, at open enrollment, of the option to receive health care services through participating MCOs.

As authorized and arranged by ODM, participating MCOs may conduct mailings to all eligibles through the State, and may send additional information to anyone who contacts the MCO directly and asks for additional information. Such information is limited to State prior-approved brochures and provider directories, copies of member newsletters, information about special member benefits, etc. The mailings are coordinated through the state and paid for by the MCO.

Referrals are done for OhioRISE enrollment. MCOs, members and their families, and other state and local child serving systems are able to refer potentially eligible members for a CANS assessment to determine if the member meets the threshold score for enrollment. If it is found that the member meets the threshold score, the state will enroll the member into OhioRISE.

b. **Administration of Enrollment Process**.

___ State staff conducts the enrollment process.

_X__ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

__X_ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Automated Health Systems, Inc.

Please list the functions that the contractor will perform:

_X__ choice counseling
_X__ enrollment
_X_ other (please describe):

Provision of enrollment opportunities by phone, by mail, online, or face to face.

- **Participation in meetings and forums with stakeholders and interested parties.**

- **Assignment of those eligibles in mandatory enrollment counties are mailed a State-generated Notice of Enrollment.**

- **Completion of enrollee-initiated Just Cause disenrollment requests.**

- **Reporting, both statistical and narrative of all Contractor activities on a monthly basis**

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

_X_ _ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

OhioRISE is a new program and enrollment will begin July 2022 statewide. As members must either be referred for a CANS

assessment or enrolled based on an inpatient admission for a behavioral health diagnosis, it is expected that enrollment will ramp up over the first year of the program.

___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

__X_ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan. **For the Medicaid managed care program**

i. _X_ Potential enrollees will have_***0***__days/month(s) to choose a plan.
ii. _X_ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

The auto-assignment algorithm is a hierarchy of multiple steps with the goal of assigning individuals to the managed care plan that best matches their needs and preserving the existing provider-patient relationships, including relationships that may exist for persons with special health care needs. If a member has been enrolled in the previous six months, he or she is enrolled into the same plan. If a member has a family member in the same Medicaid case that is currently enrolled, he or she is enrolled the same plan as the rest of his or her family. For members who do not have enrollment history, an assignment is attempted based on the Medicaid fee-for-service providers the member has utilized in the last 12 months and matching those providers to each of the managed care plans' provider networks. If the Medicaid recipient does not have an existing relationship with a Medicaid a fee-for-service provider, the managed care assignment is based on quarterly quality assessments of the managed care plans in five key health related performance standards. ODM weights the percentages of assignments to each individual managed care plan based on the results of the quality assessments. Assignments are also based on the MCO's member enrollment and provider network capacity in each county. If a MCO's ratio of member enrollment to provider network capacity is too high in a particular county, assignments will be blocked for that MCO in that county for the entire month. Enrollees have up to 90 days from enrollment to change plans without cause and after that, annually during open enrollment.

_X__ The State **automatically enrolls** beneficiaries
___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

_X__ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1) **OhioRISE enrollment is required for all members that meet the criteria specified in the Ohio Administrative Code rules 5160-59-02 and 5160-59-02.1.**

___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

_X__ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

_X__ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i._X__ Enrollee submits request to State. **For the Medicaid managed care program**

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

_X__ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area. **OhioRISE members who request to disenroll from the plan must receive a CANS assessment to determine if they no longer meet the threshold score which requires**

enrollment. The OhioRISE plan is required to assess all enrollees to receive access to the CANS assessment if they request disenrollment.

_X__ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of __***12***__ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).
Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

MCO members or authorized representatives may request to change or terminate MCO membership for just cause when the members' or authorized representatives' contacts to the MCOs are unsuccessful in identifying providers of services that would alleviate the members' need to make a just cause request.

Changing MCOs in mandatory service areas or terminating MCO membership in voluntary service areas for just cause includes the following:

(i) The member moves out of the MCO's service area and a non-emergency service must be provided out of the service area before the effective date of the member's automatic termination.

(ii) The MCO does not, for moral or religious objections, cover the service the member seeks.

(iii) The member needs related services to be performed at the same time; not all related services are available within the MCO network, and the member's PCP or another provider determines that receiving services separately would subject the member to unnecessary risk.

(iv) Poor quality of care and the services are not available from another provider within the MCO's network.

(v) Lack of access to medically necessary Medicaid-covered services or lack of access to the type of providers experienced in dealing with the member's health care needs.

(vi) The PCP selected by a member leaves the MCO's panel and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the language is available and accessible in another MCO in the member's service area.

(vii) A situation in which, as determined by ODM, continued membership in the MCO would be harmful to the interests of the member.

___ The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

_X_ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:
The state only permits this for the Medicaid managed care program:

i._X__ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

- **Fraudulent behavior by the member; or**
- **Uncooperative or disruptive behavior by the member or someone acting on the member's behalf to the extent that such behavior seriously impairs the MCO's ability to provide services to either the member or other MCO members.**

ii._X__ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii._X__ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv._X_ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. **Assurances.**

_X__ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

__X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

_X__ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs**. States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

_X__ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

_X_ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for MCO or PIHP programs**.

a. **Direct access to fair hearing**.

_X__ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing in accordance with 42 CFR 438.402.

__ _ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. **Timeframes**

__X_ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is _60__ days (between 20 and 90) in accordance with 42 CFR 438.402.

_X__ The State's timeframe within which an enrollee must file a **grievance;** at any time in accordance with 42 CFR 438.402.

c. **Special Needs**

_X__ The State has special processes in place for persons with special needs. Please describe.

MCOs and the OhioRISE plan are required to provide additional assistance to hearing-impaired, vision-impaired, limited-reading proficient and limited-English proficient members.

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

___ The State has a grievance procedure for its ___ PCCM and/or ___ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

___ The grievance procedures is operated by:

- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

___ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

___ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

___ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

___ Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

___ Establishes and maintains an expedited review process for the following reasons:_____ . Specify the time frame set by the State for this process____

___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

___ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

_X__ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
    a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
    b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. **Assurances For MCO or PIHP programs**

_X__ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

_X__ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

__X_ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication							X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	
Accreditation for Participation				X MCO and PIHP	X MCO and PIHP		X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP
Consumer Self-Report data			X MCO		X MCO		X MCO	X MCO	X MCO	X MCO		X MCO
Data Analysis (non-claims)			X MCO			X MCO			X MCO			X MCO
Enrollee Hotlines	X MCO and PIHP		X MCO and PIHP		X MCO and PIHP						X MCO and PIHP	
Focused Studies												
Geographic mapping												

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by Plan					X MCO and PIHP						X MCO and PIHP	
Ombudsman												
On-Site Review		X MCO and PIHP		X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP	X MCO and PIHP
Performance Improvement Projects							X MCO and PIHP		X MCO and PIHP			X MCO and PIHP
Performance Measures	X 1915(c)		X 1915(c)	X MCO 1915(c)			X MCO and PIHP		X MCO and PIHP	X 1915(c)	X 1915(c)	X MCO and PIHP

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
												1915(c)
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review												
Other: (describe)												

II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. __X__ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

_X__ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe):

- Applicable programs – **MCO and OhioRISE**

- Personnel responsible –**EQRO, Ohio Department of Medicaid**

- Detailed description of activity –

  ODM utilizes an external quality review organization (EQRO) to evaluate MCO compliance with access, structure/operation and quality improvement standards as specified in 42 CFR 438.358 and will use the same process for OhioRISE. In order to improve efficiencies related to the administrative review, ODM implemented the deeming option in accordance with 42 CFR 438.360. ODM will direct the EQRO to complete a comprehensive evaluation of the comparability of access, structure and operations, and measurement and improvement CFRs to the National Committee for Quality Assurance (NCQA) Health Plan Accreditation standards. The standards

identified as eligible for deeming will be cited in the Medicaid Managed Care Quality Strategy.

To ensure MCO and OhioRISE compliance with CMS regulations, and for the related standard to be exempt from review, the MCO or OhioRISE plan scores on the accreditation standard/element must be 100 percent of the point value during the most recent accreditation survey (within a recent 3-year period). As part of the administrative compliance assessment planned for MCOs for 2023 and 2024 for OhioRISE, the EQRO will review each MCE's most recent accreditation survey and determine which of the elements will be deemed based on the MCE's score on the related accreditation standard. Deemed standards will be designated as "met" on the standardized data collection tool used for the administrative compliance assessment.

- Frequency of use **-**
  The information from the deeming review is part of the administrative compliance assessment evaluations that are performed to comply with 42 CFR 438.358. The next comprehensive administrative review for MCOs is scheduled for 2023 and for the OhioRISE is tentatively scheduled for 2024.

- How it yields information -
  Overall, the information from the accreditation survey reports combined with the results from the compliance assessment assist ODM in: (1) evaluating the quality and timeliness of, and access to, care and services furnished to members; and (2) identifying, implementing and monitoring interventions to improve quality, timeliness, and accessibility of services.

b. _X___ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

_X_ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

- Applicable programs – **MCO and OhioRISE**

- Personnel responsible –**Ohio Department of Medicaid**

- Detailed description of activity –
  Medicaid MCOs are required to pursue and maintain an acceptable level of NCQA accreditation. NCQA's accreditation is considered the industry "gold standard" for ensuring that a health plan's structure, processes, and outcomes yield improvements in quality health care and consumer experiences.

- Frequency of use **-**
  On an annual basis, ODM will verify the OhioRISE plan and each MCO's accreditation status to evaluate compliance with ODM's requirements. Based on the evaluation, ODM will evaluate if the MCO received an acceptable level of accreditation as outlined in the provider agreement. ODM regards the Accredited status as acceptable. A Provisional status will result in a re-survey, within 12 months of the accreditation decision. If the survey results are a Provisional or Denied status, ODM will consider this a material breach of the Provider Agreement and may terminate the Agreement. A Denied status is also considered a material breach of the Agreement which may be terminated. ODM is working with NCQA to develop a customized set of standards that will be applicable for OhioRISE to meet for annual specialized accreditation. Based on NCQAs rubric that will apply to these standards, ODM will evaluate if the OhioRISE plan received an acceptable passing score to maintain the specialized accreditation status. A survey result that falls below the acceptable status will result in a re-survey within 12 months of the accreditation decision. If the survey results are a Provisional or Denied status, ODM will consider this a material breach of the Provider Agreement and may terminate the Agreement. A Denied status is also considered a material breach of the Agreement which may be terminated. Accreditation status is published on the ODM website pursuant to NCQA guidelines and federal requirements.

- How it yields information -
  Information from this activity will be used to evaluate the plan's ongoing commitment to establish and maintain structures and processes that represent the principles of continuous quality improvement: evidence-based guidelines, transparency, accountability, informed consumer choices, value and consistency/continuity. Information from this activity may also be used in the comprehensive administrative review process as part of ODM's effort to reduce duplication of oversight with the external quality review organization.

c. __X___ Consumer Self-Report data
__X_ CAHPS (please identify which one(s)) – **CAHPS 5.0H Adult Medicaid Health Plan Survey and CAHPS 5.0H Child Medicaid Health Plan Survey (with the chronic conditions measurement set)**
__X_ State-developed survey –Special Population Field Reviews
___ Disenrollment survey
___ Consumer/beneficiary focus groups

RESPONSE:

CAHPS

- Applicable programs – **MCO**
- Personnel responsible – **MCO, EQRO, Ohio Department of Medicaid**
- Detailed description of activity –

  ODM requires contracting MCOs to administer the CAHPS 5.0H Adult Medicaid Health Plan Survey and the CAHPS 5.0H Child Medicaid Health Plan Survey (with the chronic conditions measurement set) on an annual basis and to submit their survey data to ODM, the National Committee for Quality Assurance (NCQA), and the Agency for Healthcare Research and Quality's (AHRQ's) CAHPS Database. These requirements, and sanctions for not meeting these requirements, are set forth in the state's Provider Agreement with the MCOs. Detailed requirements are provided in the ODM CAHPS Survey Administration and Data Submission Specifications document, which is updated annually and posted online at: CAHPS Consumer Experience Surveys | Medicaid (ohio.gov). **These specifications contain requirements intended to standardize data collection and facilitate the comparison of results across MCOs.**

  The state's EQRO (Island Peer Review Organization) analyzes the MCO's CAHPS data and prepares reports of findings for the state. Data are analyzed in accordance with NCQA Healthcare Effectiveness Data and Information Set (HEDIS) specifications for survey measures. Reports produced include an Executive Summary Report, a Full Report, and a Methodology Report. National Medicaid results are included in the Full and Executive Summary reports.

  ODM staff provide overall direction, oversight and monitoring for the CAHPS requirements. This includes establishing policy, drafting and/or revising contract language and associated specifications, working with various entities (e.g., MCOs, survey vendors, NCQA, the CAHPS Database) to ensure timely and accurate MCO data submissions, establishing analytic and reporting requirements, finalizing reports, and providing technical assistance.

- Frequency of use –

  ODM's contracted MCOs administer the CAHPS 5.0H Adult Medicaid Health Plan Survey and the CAHPS 5.0H Child Medicaid Health Plan Survey (with the chronic conditions measurement set) annually.

- How it yields information about the area(s) being monitored –
  The surveys assess consumer experience with healthcare. Specific areas addressed include access to care, quality of care, the communication skills of providers, and health plan customer service. Respondents provide overall ratings of health plans, health care, and providers. Reports of findings are issued to the MCOs and posted to the ODM Managed Care webpage: http://medicaid.ohio.gov/MEDICAID101/QualityStrategyandMeasures.aspx **Findings from these reports are used by ODM and/or the MCOs in a number of ways. Specific rates are used for benchmarking and performance evaluation. CAHPS results are incorporated into standard reports (e.g., Ohio's EQRO Technical Report) and relevant ad hoc analyses. MCOs may use the findings to achieve or maintain NCQA health plan accreditation. Finally, areas of poor performance may indicate a need for further research (e.g., drill down analysis) and/or identify opportunities for quality improvement.**

Special Population Field Reviews

- Applicable programs – **MCO**

- Personnel responsible – **Ohio Department of Medicaid**

- Detailed description of activity – **ODM is increasing its focus on the prevention of harm to Medicaid consumers, specifically special populations, enrolled in the managed care delivery system. As part of this strategy, ODM will utilize clinical field staff to conduct face-to-face interviews of special populations enrolled in managed care. The face-to-face interviews assess if the children's medical and behavioral health needs are being met in the managed care delivery system.**

- Frequency of use - **As needed.**

- How it yields information about the areas being monitored –
  Information about the reviews will be used to identify if any gaps in care exist and, if so, they will be reported back to the child's managed care plan for remediation. In addition, overall results will be used to assess the performance of managed care in meeting the needs of children with special health care needs.

d. __X___ Data Analysis (non-claims)

___ Denials of referral requests

_X__ Disenrollment requests by enrollee

_X_ From plan

__ From PCP within plan

__X_ Grievances and appeals data

___ PCP termination rates and reasons

__X_ Other (please describe): Care management data

Disenrollment Requests by Enrollee

- Applicable programs – **MCO**

- Personnel responsible – **Ohio Department of Medicaid, Medicaid Consumer Hotline personnel**

- Detailed description of activity –

  Members who wish to disenroll from an MCO must contact the Ohio Medicaid Consumer Hotline by phone, through the mail or via the Internet. Members can disenroll during their initial three months of membership, the annual open enrollment period and for Just Cause. Members can also disenroll if they meet any one of the exempted criteria. Those members who are exempted from managed care will be returned to traditional fee for service Medicaid. All other members must select another MCO.

- Frequency of use –

  Daily, dependent on member's needs

- How it yields information –

  Disenrollment is then tracked by the Ohio Medicaid Consumer Hotline and reported to ODM. ODM uses this information to identify trends to determine access issues. The trends are reported to MCOs to find out why their members are having difficulty accessing care from their providers. A determination is then made if a corrective action plan or fine is required.

Grievances and Appeals Data

- Applicable programs – **MCO**

- Personnel responsible – **MCOs, Ohio Department of Medicaid**

- Detailed description of activity –

MCO members can contact their MCO to file grievances and appeals. Members file grievances to express their dissatisfaction with their MCO or the MCO's providers for a variety of reasons (e.g., inadequate access to care). Members file appeals in order to obtain a review of MCO actions such as the denial, reduction, suspension or termination of services. The MCO is required to resolve all grievances and appeals.

- Frequency of use –
  MCOs are required to submit data files to ODM that document grievances and appeals received during the prior month in all regions for which the MCO has a provider agreement. MCOs submit a monthly grievance file which includes a specific description and resolution for certain required grievance categories and a numeric count of other specified grievance categories. A monthly appeal file is also required which includes all appeals. The MCO's files must be submitted in the required text format by the 15th of each month.

- How it yields information –
  ODM staff review monthly representative samples of access related grievances and other non-access related grievances to verify accurate categorization, adequate resolution and to identify patterns. ODM staff review 100% of appeals. Effective January 1, 2017, file specification changes were implemented that require plans to report additional information regarding the type of service appealed and type of service for panel access/service authorization grievances. Additionally, new categorization codes were added to further delineate the grievance issue. As a result, for appeals, the monthly representative appeal review was changed and ODM staff now utilize system report capabilities to determine resolution timeliness and identify trends by MCO and across MCOs related to the number of records, reported issue, type of service, and resolution. Finally, a targeted detail level review of each MCO's grievance file records is conducted three (3) times per year. Audits may occur to evaluate appropriate identification and submission of grievances or in response to any observation in reported appeals or grievances to assure compliance with program requirements. Compliance action is taken by ODM following the review of grievances and appeals if it is determined that the grievance or appeal issue was not resolved or the MCO is in violation of a program requirement.

Care Coordination Data

- Applicable programs – **MCO**

- Personnel responsible –**MCOs, Ohio Department of Medicaid**

- Detailed description of activity –
  MCOs are required to submit quarterly data files to ODM in accordance with ODM's file specifications.. The data are used to monitor MCO performance as it relates to population health management. ODM works with the EQRO to build an interactive application that provides ODM with the ability to query relevant data elements, trend data, and compare descriptive statistics across plans and programs.
  Frequency of use –
  As needed by ODM staff.

- How it yields information –
  The data will inform ODM of the extent to which MCOs are managing their overall population.

e. __X___ Enrollee Hotlines operated by State

- Applicable programs – **MCO and OhioRISE**

- Personnel responsible –**Hotline personnel, state Medicaid**

- Detailed description of activity –
  Ohio Medicaid employs an independent contractor to provide unbiased, objective information to beneficiaries regarding their MCO choices. Approximately 95 percent of beneficiary-initiated enrollment activities occur via the Ohio Medicaid Consumer Hotline statewide toll-free phone system, though enrollment opportunities are also available by mail and on-line. ODM notifies eligible beneficiaries by mail about managed care membership. The notice explains the beneficiaries' obligation to select a health plan, options on how to enroll, membership rights and responsibilities. The notice also indicates that beneficiaries must contact the Ohio Medicaid Consumer Hotline by a specific date to voluntarily enroll or they will be assigned to a health plan. A reminder notice is mailed after the initial notice, if a beneficiary fails to choose a health plan. The reminder notice, mailed to beneficiaries by the Ohio Medicaid Consumer Hotline, identifies the health plan to which the beneficiary will be assigned if a health plan is not selected by a date specified in the notice. Beneficiaries can change MCOs during their initial 90 days of enrollment, for Just Cause, and during the annual open enrollment month in November.

  Ohio Medicaid will also use the independent contractor to provider information on the OhioRISE program. Members who request either enrollment into or disenrollment from OhioRISE may call the hotline where the hotline staff can provide information on how to obtain a CANS assessment in order to determine if the member is eligible to enroll in or no longer meets the threshold score and can be disenrolled from OhioRISE.

- Frequency of use –
  The contract is monitored by the State with on-site visits, reporting, and semi-annual reviews.

- How it yields information –
  The primary purpose for these monitoring activities is to determine the level of compliance to contractual deliverables or to determine if there are any access to care issues in either the MCOs or OhioRISE. If it is determined the contractor is out of compliance, a corrective action plan is requested and eventual financial penalties could be assessed if the activity is not corrected to the satisfaction of ODM.

f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. __ ___ Geographic mapping of provider network

h. __ ___ Independent Assessment of program impact, access, quality, and cost-effectiveness (Required for first two waiver periods)

i. __X___ Measurement of any disparities by racial or ethnic groups

- Applicable programs**- MCOs**
- Personnel responsible **–**
  The Medicaid Managed Care Plans have contracts with ODM which require them to submit performance measures using HEDIS methodology Ohio has been working to collect complete race data and develop analytical capacity for stratifying this data.

- Detailed description of activity -
  ODM has adopted the U.S. Department of Health and Human Services—Office of Minority Health's definition of health disparities as "a particular type of health differences that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion."

ODM worked with the previous five MCOs and provider networks to increase the comprehensiveness of race and ethnicity data. This is necessary due to the inability to require these demographic fields as part of the Medicaid application process, which has resulted in up to 20 percent missing data. ODM has hired a full-time health equity program manager to spearhead this effort. The additional data will allow further stratification by racial and/or ethnic groups which will help refine and guide the Health Equity Strategy and will allow ODM to track progress in reducing these differences.

ODM has also revised the MCO contract to require MCOs to stratify data by race or ethnicity when possible (e.g., CAHPs data).

ODM has also updated the Managed Care Provider Agreement to require participation of managed care plans in ODM's Health Equity Initiatives. This includes having health equity representatives actively involved in ODM required improvement projects with an equity focus and having MCO representatives actively contribute to workgroups charged with determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts. This revision of the Health Equity Workgroup is intended to focus on work needed for change to occur and places greater responsibility on participating parties.

As part of its performance improvement projects, with managed care plans and clinical partners, ODM has also begun exploring obtaining demographic data such as race from electronic health record data. Managed care plans are currently tracking hypertension control among members seen by practices participating in the Hypertension Control PIP. ODM will continue to explore this method of data collection and stratification in future PIPs, such as the Diabetes Control PIP that is currently in the planning phase.

- Frequency of use -
  The frequency of data collection and analysis will depend on priority areas being addressed in ODM's quality strategy. For the PIP described above, MCOs are able to see data every two weeks.

- How it yields information -
  The data will yield information regarding progress in reducing health disparities across multiple areas and populations. Programs that address health disparities by racial and ethnic group are most likely to be implemented across the Medicaid population rather than specifically for

children with special healthcare needs. However, further stratification by age and enrollment group can help assure that reductions in disparities are observed across the entire Medicaid population.

j. __X___ Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

- Applicable programs – **MCO and OhioRISE**

- Personnel responsible –**MCOs, OhioRISE, Ohio Department of Medicaid**

- Detailed description of activity –

  The assurance of adequate network access to health care services for Medicaid managed care and OhioRISE enrollees is based on provider panel requirements. The State requires a minimum primary care provider (PCP) capacity for each MCO in a county, to help assure adequate capacity to serve a specified portion of eligible individuals in that county. Notwithstanding the minimum provider panel requirements, the MCO must ensure access to all medically necessary services for their beneficiaries.

  In accordance with 42 CFR 438.206, ODM requires the MCOs and the OhioRISE Plan to maintain a provider network that is sufficient to provide timely access to all medically necessary covered services stipulated in the Plan benefit package to all enrolled members, including those with limited English proficiency or physical or mental disabilities. The MCOs and OhioRISE Plan must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities. All plans must monitor compliance with provider network requirements and take corrective action as needed.

  The OhioRISE plan must have a sufficient number of mental health and substance use disorder providers to be able to serve the needs of the member. The OhioRISE plan will work with Ohio Medicaid to develop a network of new providers for Intensive Case Management and Moderate Case Management services.

- Frequency of use -

  The State monitors minimum network requirements monthly via the Managed Care Provider Network (MCPN), a database that tracks the number and type of providers in the OhioRISE plan and MCOs' provider networks and generates reports to indicate compliance with the ODM minimum panel requirements outlined in the Provider Agreements.

  To assure adequate access to network providers, the OhioRISE Plan must submit quarterly time and distance reports (TDRs) to ODM in the format specified by ODM. The OhioRISE Plan must notify ODM within one

business day of determining that it is not in compliance with the provider network access requirements detailed above.

- How it yields information -
  ODM has minimum network requirements for specialists and other provider types as a way of assuring that beneficiaries have access to Medicaid-covered services. Required provider types include: primary care physicians (PCPs) hospitals, dentists, pharmacies, vision care providers, obstetricians/gynecologists (OB/GYNs), allergists, gastroenterology, general surgeons, nephrology, neurology, oncology, nursing facility, otolaryngologists, orthopedists, pediatricians, physical medicine and rehab, podiatry, psychiatry, certified nurse midwives (CNMs), certified nurse practitioners (CNPs), federally qualified health centers (FQHCs)/rural health centers (RHCs), qualified family planning providers (QFPPs), and urology.

  ODM uses geo mapping software that incorporates Euclidean metric to measure the maximum time and distance for the MCOs and OhioRISE Plan's membership and provider network. The Plans must ensure that at least 90% of the Plan's members have access to at least one provider/facility of each specialty type within their county of residence who are located within the ODM-determined time and distance standards.

k. ____ Ombudsman

l. __X___ On-site review

- Applicable programs – **MCO, OhioRISE**

- Personnel responsible –**EQRO, Ohio Department of Medicaid, other designees as appropriate**

- Detailed description of activity –
  The external quality review organization or ODM may review the following domains: availability of services, assurance of adequate services and capacity, coordination and continuity of care, coverage and authorization of services, credentialing and recredentialing, subcontracting and delegation, marketing, member rights and information, confidentiality of health information, enrollment and disenrollment, grievance process, quality assessment and performance improvement programs, health information systems, and program integrity. Information from the reviews is used to: 1) determine compliance with state and federal regulations; 2) evaluate the quality and timeliness of, and access to, care and services furnished to members; and 3) identify interventions to improve quality, timeliness, and accessibility of services.

- Frequency of use -
  Reviews are primarily conducted in conjunction with the comprehensive administrative reviews that are completed every three years to comply with 42 CFR 438.358; however, focused reviews on an annual basis may be conducted at the discretion of ODM.

- How it yields information -
  Upon completion of the reviews, if the EQRO identifies areas of noncompliance, the MCOs and OhioRISE plan will be required to develop and implement a Corrective Action Plan (CAP) in order to remedy the deficiency.

m. _X___ Performance Improvement projects [Required for MCO/PIHP]
_X__ Clinical
_X__ Non-clinical

- Applicable programs - **Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs) are an integral part of improving the overall quality of care in Ohio's Medicaid population. As outlined in the Provider Agreement, each MCO and the OhioRISE plan must conduct Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs) in clinical and non-clinical areas.**

- Personnel responsible -
  Each year, ODM selects a PIP topic that the Medicaid Managed Care plans will collaboratively address in order to meet the requirements of 42 CFR 438.330. The EQRO annually evaluates the PIPs in accordance with Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities (CMS Protocols). ODM expects MCOs to adhere to ODM-specified reporting, submission and frequency guidelines.

  Managed Care plans also participate in QIPs that, unlike the PIPs, are not validated by the EQRO. However, QIPs use the same rapid-cycle IHI-like methods and tools to achieve improvement. Recent QIPs that managed care plans are collaboratively undertaking independently of ODM include efforts to increase well child visit and immunizations.

- Detailed description of activity
  Each year, ODM selects PIP topics that reflect the Ohio Medicaid quality strategy priority areas. In addition, ODM may also require the MCOs or OhioRISE plan to participate in quality improvement projects (QIPs) that address burgeoning issues or high priority clinical issues for the Ohio

Medicaid managed care population. Although QIPs are not validated by the EQRO, they are undertaken with the same scientific rigor.

Performance Improvement Projects (PIPs) are an integral part of improving the overall quality of care in Ohio's Medicaid population. As outlined in the Provider Agreement, each MCO and OhioRISE plan must conduct Performance Improvement Projects (PIPs) in clinical and non-clinical areas. ODM expects PIPs to be multi-year structured quality improvement projects that yield favorable health outcomes and improved experiences of care for Medicaid managed care consumers. PIPs may vary between the OhioRISE plan and the MCOs, but ODM may direct each plan to complete a PIP based on areas consistent with the goals of each program and in line with the quality strategy.

PIP components validated by the EQRO are based on the IHI Model for Improvement: (1)PIP initiation which answers the question "What are we trying to accomplish?" and includes internal and external team building and partner identification, as well as PIP topic rationale and the documentation of intrinsic theories regarding change through a key driver diagram; (2)SMART Aim data collection which answers the question of "How we will know a change is an improvement?" and consists of determining the data collection strategy and methodology to assess measure improvement; (3) Intervention Determination which answers the question "What changes can we make that will result in improvement" and encompasses research into internal processes and procedures as well as external research regarding evidence-based practice and known interventions; (4)Plan, Do, Study, Act (PDSA) cycles to test interventions and further evolve the interventions selected in Module 3, as well as further inform the theory developed in Module 1; and (5.) PIP conclusions where opportunities for sustainability and spread are assessed.

At the end of each phase, the MCOs and OhioRISE plan must submit the above Modules to ODM and the EQRO to illustrate progress. If additional information is needed or deficits are identified, the module will be returned to the plan for updates. Progress through the modules is a step-wise process, with approval of each module being required before a plan can advance to the next module.

- Frequency of use
  PIP topics are chosen for implementation over a 24 -month period, with the first 12 months involving practice recruitment, data use agreements and baseline data collection. Each PIP includes a theory of change as exemplified by a Key Driver Diagram (KDD). The KDD puts forth the plan for improvement by explicitly outlining the key drivers of the problem and interventions that can impact these. Plans are required to test each

intervention using Plan-Do-Study-Act (PDSA) cycles to allow for more efficient and effective determination of intervention effectiveness, scalability and sustainability. Each MCO submits biweekly data documenting progress toward the goal and annotating when an intervention began so that its impact can be observed. ODM will use a consistent process for the OhioRISE program.

- How it yields information about the area(s) being monitored
  For CYs 2015 and 2016, the required PIP aligned with Ohio's quality strategy priority of promoting evidence-based prevention and treatment processes, the State of Ohio priority to address infant mortality, and the clinical focus area of preventing premature births. Babies born preterm, before 37 weeks of pregnancy, can experience major health problems and lifelong disabilities. The PIP therefore focused on preventing premature births through promoting early identification of pregnant women at risk of preterm birth, standardization of MCO processes, and using care management to remove barriers to evidence based care. SSI child waiver consumers of child-bearing age were included in this PIP.

  During CYs 2017 and 2018, Ohio's MCOs worked to increase the timeliness of data exchange with Ohio's Comprehensive Primary Care practices allowing for better population health and care management.

  For CYs 2018 and 2019, the required PIP aligned with Ohio's quality strategy priority of improving the health outcomes of those with chronic conditions by focusing on identifying and refining proven strategies to increase hypertension control, with a special focus on reducing disparities for African Americans The Hypertension Control and Disparity Reduction PIP is unique in that it uses data from the participating clinical practices' electronic health records to identify and track patient outcomes.

  In addition, during CYs 2017 and 2018, Ohio's MCOs worked to increase the timeliness of data exchange with Ohio's Comprehensive Primary Care practices allowing for better population health and care management.

  The IHI-based methodology used for all PIPs and QIPs allows for more efficient and effective intervention selection and more frequent data collection. This allows a more rapid determination of intervention effectiveness in moving outcomes in the desired direction, regardless of the population.

n. __X___ Performance measures [Required for MCO/PIHP]

Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics
Beneficiary characteristics

- Applicable programs – **MCO and OhioRISE**

- Personnel responsible –**MCO, OhioRISE plan, Ohio Department of Medicaid**

- Detailed description of activity –
  See the descriptions below for the clinical and financial performance measures activities used through calendar year 2021 and the list of proposed measures beginning in 2022.

  The performance measures used to monitor children's health processes and outcomes, access to care, and utilization of services for members in MCOs (including the OhioRISE plan in 2022) are aligned with ODM's Quality Strategy. Using a population health approach, ODM's quality strategy defines specific sub-populations on which to focus monitoring activities. These sub populations, or population streams, were developed based on prevalence and cost analyses of Covered Families and Children (CFC) and the Aged, Blind, and Disabled (ABD) child and adult populations in Ohio's Medicaid program. Performance measures selected for this waiver align with children populations served by MCOs and the OhioRISE plan namely, the Healthy Children and Behavioral Health population streams.

  Beginning in 2022, with implementation of OhioRISE, ODM is proposing to use the following performance measures to monitor access, quality, and use of service:

Follow-Up After Hospitalization for Mental Illness (FUH)

- **6–17 years.**

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

- **1–11 years.**
- **12–17 years.**

Well-Child Visits in the First 30 Months of Life (W30)

- **Well-Child Visits in the First 15 Months (6 or more visits).**
- **Well-Child Visits for Age 15 Months–30 Months (2 or more visits).**

Child and Adolescent Well-Care Visits (WCV)

- **3–11 years.**
- **12–17 years.**
- **18–21 years.**
- **Total.**

- Frequency of use –
  Annually (clinical and financial performance measures)
  Quarterly (financial performance measures)

- How it yields information about the areas(s) being monitored –**The state uses performance measures to monitor access and assure quality health care delivery and health plan financial stability/cost of care.**

  ***Activity*: Clinical and access performance measures.**

- Process **The performance measures for the SFY 2021 and 2022 contract year (CY 2020 & CY 2021 measurement years) are designed to monitor Quality Strategy Focus Areas, by population stream, which were developed based on prevalence and cost analyses of Covered Families and Children (CFC) and the Aged, Blind, and Disabled (ABD) child populations in Ohio's Medicaid program. The performance measure results are evaluated on an annual basis. Most of the measures are focused on assessing specific health outcomes for the ABD and CFC child populations but are also process measures which monitor use of services for the managed care plan members.**

  The new measures will focus on overall reduction in institutional placement as well as out of state placements to ensure quality of care and better quality of life. Process measures of follow ups after hospitalizations will be used to align with the benefits provided at the OhioRISE plan as well as coordination with the MCOs. Most OhioRISE specific measures established in the provider agreement will be reporting only in the first years of the contract and then moving to a minimum performance standard where when the OhioRISE plan does not meet the minimum, a financial or other penalty will be assessed.

Health Status/outcomes –

MCO performance measures include Healthcare Effectiveness Data and Information Set (HEDIS) measures, as well as a Children's Health Insurance Program Reauthorization Act (CHIPRA) Low birth weight measure and a measure related to tobacco use cessation. The MCOs are responsible for submitting self-reported audited HEDIS results to the National Committee for Quality Assurance (NCQA) and ODM through Ohio's external quality review organization (EQRO) which will review the HEDIS results and Final HEDIS Audit Reports (FARs) submitted by the MCOs and recommend to ODM if the results should be used for performance evaluation (if there are Not Report [NR] or Not Applicable [NA] results). ODM reserves the final authority to determine if the MCOs' self-reported audited HEDIS results are to be used in performance evaluation. The list of performance measures reported for CY 2020 (the most recent annual reporting year for which results are available) are listed in Section C(n), Table 1. The non-HEDIS measures are calculated by the EQRO. The provider agreement specifies compliance actions associated with not meeting minimum performance standards for applicable measures.

The results of the performance measures will be used to assess if MCOs are meeting the health care outcome goals associated with the Quality Strategy population streams: Healthy Children, Behavioral Health, and Chronic Conditions.

The OhioRISE plan will be required to coordinate with the MCOs on MCO performance measures that could be impacted by the performance of the OhioRISE plan and incorporate reporting requirements into the provider network contracts of the OhioRISE plan.

- Access/availability of care–

The access/availability of care measures are listed under the Healthy Children stream. The performance measure results include all MCO Medicaid consumers meeting methodological criteria and are not limited by population (i.e. MAGI, ABD). These measures are used to monitor child an adolescent, access to primary, preventive and ambulatory care services (see Section C(n), Table 1) and assess managed care plan performance related to accessing care primary care services, which serve as the first contact and principle point of continuing care for members. These are also considered process measures (i.e. monitoring primary care utilization). It should be noted that measures within other populations streams are also used to monitor access to care (e.g., Behavioral Health, Chronic Conditions/Diabetes). The requirements for MCO self-reported HEDIS results, and compliance assessment (as specified above under 'Health Status/Outcomes') apply to the access/availability of care measures.

- Use of Services – **Clinical and access performance measures designed to monitor the specific population streams are also process measures which monitor service utilization (see 'Health Status/Outcomes' and 'Access/Availability of Care' above)**

  Activity: Financial performance measures:

  Ohio utilizes several strategies to monitor health plan stability/financial/cost of care. Ohio contracts with an outside actuary to develop capitation rates. The actuary uses a wide range of data which includes cost information in encounter data, National Association of Insurance Commissioners, (NAIC) Financial statements and cost reports to ensure that the capitation rates paid to the MCOs are actuarially sound and reflective of the cost of providing care.

  The cost reports are monitored to analyze both the MCOs administrative and medical costs. The MCOs are also required to submit answers to an annual rate setting survey which is evaluated to reveal any areas of financial concern. Finally, Ohio requires MCOs to carry reinsurance to provide protection against any catastrophic inpatient related medical expenses the MCOs may incur.

  The MCOs are required to submit quarterly and annual NAIC financial statements to ODM. Data from these financial statements are aggregated by plan and allow Ohio to monitor designated financial performance measures such as defensive interval, current ratio, administrative expense ratio, overall expense ratio and minimum medical loss ratio. The MCOs are also required to submit ODM designated cost reports on a quarterly and annual basis.

  On an annual basis, Ohio's actuary conducts a reconciliation between the annual NAIC financial statements and the annual cost report. This activity serves as an additional data point in assuring consistency and accuracy between what the MCOs report to the NAIC and to ODM. The reconciliation also assures greater accuracy in accounting for revenue and expenses when setting annual capitation rates.

  Within ODM, the Managed Care Rate Setting section monitors the MCOs for financial stability and cost of care.

- Health plan/provider characteristics – **The performance measures provide the state with the ability to analyze trends and performance by health plan.**

- Beneficiary characteristics – **The performance measures for the SFY 2021 contract year (CY 2020 measurement year) were designed to monitor Quality Strategy population streams which were developed based on prevalence and cost analyses of MAGI and the Aged, Blind, and Disabled (ABD) child and adult populations in Ohio's Medicaid program.**

o. ____ Periodic comparison of number and types of Medicaid providers before and after waiver

p. ____ Profile utilization by provider caseload (looking for outliers)

q. ____ Provider Self-report data
___ Survey of providers
___ Focus groups

r. _____ Test 24 hours/7 days a week PCP availability

s. _____ Utilization review (e.g. ER, non-authorized specialist requests)

t. _____ Other: (please describe)

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

___ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

_X__ This is a renewal request.

- _ __ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
- _X__ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:
Confirmation it was conducted as described:
___ Yes
___ No. Please explain:
Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

a. **__*X*__ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)**

_X__ NCQA
___ JCAHO
___ AAAHC
_ __ Other (please describe):

Confirmation it was conducted as described:
_ __ Yes
_X__ No. Please explain:
Summary of results:
The most recent comprehensive administrative review was performed in Spring 2020. ODM requested that the EQRO complete a review of the 2017, 2018, and 2019 NCQA standards to identify areas of overlap with the deem able Code of Federal Regulations (CFRs). Only those accreditation standards that were 100 percent comparable to the CFRs were eligible for deeming for the Spring 2020 administrative review. Furthermore, ODM required that for an MCO to be exempted from review of a deemed standard, the MCO must be fully compliant with the comparable accreditation standard. ODM updating the Medicaid Managed Care Quality Strategy with the duplicative standards that were identified in the deeming process.

Problems identified: Not applicable.
Corrective action: Not applicable.
Program change: Not applicable.

b. _X___ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)
_X_ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:

Summary of Results: All MCOs are currently NCQA accredited and have maintained an acceptable level: excellent, commendable, or accredited. All MCOs are compliant with this requirement.
Problems identified: Not applicable.
Corrective action: Not applicable.
Program change: Not applicable.

Strategy: Consumer Self-Report data - CAHPS

c. __X___ Consumer Self-Report data
__X_ CAHPS (please identify which one(s)) **CAHPS 5.0H Adult Medicaid Health Plan Survey, and CAHPS 5.0H Child Medicaid Health Plan Survey (with the chronic conditions measurement set).**
__ _ State-developed survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:

Summary of results:
ODM requires each MCO to contract with an NCQA-certified HEDIS survey vendor to administer the *CAHPS 5.0H Adult Medicaid Health Plan Survey* and the *CAHPS 5.0H Child Medicaid Health Plan Survey (with the chronic conditions measurement set)* on an annual basis and to submit their survey data to ODM, the National Committee for Quality Assurance (NCQA), and the Agency for Healthcare Research and Quality's (AHRQ's) CAHPS Database. ODM requires the MCOs to follow *NCQA HEDIS Specifications for Survey Measures* in administering the surveys. The MCOs must also adhere to *ODM CAHPS Survey Administration and Data Submission Specifications* for this requirement that are intended to standardize data collection and facilitate the comparison of results across plans. These specifications include requirements for care supplemental questions to the survey instrument, using a mixed mode of survey administration, and oversampling the adult population. The specifications are updated annually and available at:

https://medicaid.ohio.gov/Provider/ManagedCare/ManagedCareProgramAppendix

ODM contracts with *Island Peer Review Organization (IPRO)*, the state's EQRO, to analyze the MCOs' CAHPS data and to prepare annual reports of findings. Results are calculated in accordance with *NCQA HEDIS Specifications for Survey Measures.* Adult and child data is analyzed separately at the Ohio Medicaid and MCO levels, and no weighting or case-mix adjustment is performed on the results. A separate analysis comparing the population of Children with Chronic Conditions (CCC) to the non-CCC population is performed. Reports include an initial Summary Report that contains MCO and state-level results for the core measures. Three survey reports follow: an Executive Summary Report, a Full Report, and a Methodology Report. National Medicaid results and the CCC comparative analysis results are included in the Executive Summary and Full Reports. CAHPS reports are issued to the MCOs and posted to the following ODM Managed Care webpage: http://medicaid.ohio.gov/RESOURCES/ReportsandResearch/MedicaidManagedHealthCareReports.aspx#804490-cfc-program-reports

Specific questions on the child survey are used to identify the CCC subgroup. While CCC results are not based on waiver eligibility, they are likely representative of the child waiver population, based on the screening questions used to identify the subgroup, including:

- **Child need or uses of prescription medication;**
- **Child needs or uses more medical, mental health, or education services than other children the same age and need or use;**
- **Child has limitations in the ability to do what other children of the same age do;**
- **Child needs or uses special therapy; and**
- **Child needs or uses mental health treatment or counseling**

The 2016 CAHPS survey was administered in spring 2016. A total of 4,613 parents or caregivers of child consumers completed the survey. A total of 2,395 completed surveys, or 52 percent, represented children identified as having chronic conditions.

The table below provides 2018 through 2020 CAHPS top box scores for the CCC and non-CCC populations for measures pertaining to children with chronic conditions. The t values represent the percentage of respondents whose responses to survey questions indicated excellent performance.

.

2015 (pre-waiver) and 2018 - 2020 CAHPS CCC and Non-CCC Statewide Top Box Scores			
	Year	**CCC Population**	**Non-CCC Population**
Global Ratings			
Rating of Health Plan	2015	82.45%	85.64%
	2018	84.8%	85.9%
	2019	84.1%	86.2%
	2020	85.3%	88.6%
Rating of All Health Care	2015	84.85%	86.16%
	2018	86.4%	88.3%
	2019	87.8%	89.3%
	2020	89.2%	91.0%
Rating of Personal Doctor	2015	88.16%	88.16%
	2018	90.1%	89.7%
	2019	91.8%	89.5%
	2020	91.0%	90.3%
Rating of Specialist Seen Most Often	2015	86.27%	83.91%
	2018	88.4%	89.0%
	2019	88.4%	90.6%
	2020	88.7%	86.3%
Composite Measures			
Getting Needed Care	2015	89.82%	87.54%
	2018	91.6%	88.8%
	2019	90.2%	87.9%
	2020	91.0%	88.7%
Getting Care Quickly	2015	93.97%	91.46%
	2018	94.1%	92.2%
	2019	94.0%	91.4%
	2020	95.2%	91.3%
How Well Doctors Communicate	2015	94.86%	94.00%
	2018	96.2%	94.1%
	2019	96.7%	95.9%
	2020	97.4%	96.0%
Customer Service	2015	89.74%	89.56%
	2018	90.2%	92.8%
	2019	90.8%	88.2%
	2020	90.3%	89.9%
Shared Decision Making	2015	85.83%	76.94%

	2018	86.3%	75.0%
	2019	86.2%	81.0%
	2020	Survey removed	Survey removed
Individual Items			
Health Promotion and Education	2015	76.97%	71.30%
	2018	79.1%	69.8%
	2019	78.4%	71.5%
	2020	Survey removed	Survey removed
Coordination of Care	2015	84.75%	84.07%
	2018	87.0%	85.2%
	2019	86.3%	86.2%
	2020	88.4%	90.2%
CCC Composite Measures			
Family-Centered Care (FCC): Personal Doctor Who Knows Child Composite	2015	91.03%	88.89%
	2018	92.5%	89.9%
	2019	93.1%	90.6%
	2020	92.7%	94.6%
Coordination of Care for Children with Chronic Conditions Composite	2015	76.75%	74.98%
	2018	78.1%	75.5%
	2019	75.5%	74.5%
	2020	76.9%	68.6%
Access to Specialized Services Composite	2015	80.20%	80.34%
	2018	82.6%	78.0%
	2019	80.6%	80.7%
	2020	79.8%	77.6%
CCC Items			
Access to Prescription Medicines	2015	91.37%	93.39%
	2018	93.1%	94.5%
	2019	92.2%	92.0%
	2020	92.5%	92.2%
FCC: Getting Needed Information	2015	91.66%	88.97%
	2018	92.7%	89.4%
	2019	94.0%	88.8%
	2020	95.0%	88.1%

Overall CAHPS survey results demonstrated moderate to high levels of child waiver consumer satisfaction, as evidenced by scores for the CCC population. The SFY 2018 – SFY2020 CCC population results were similar to the SFY 2015 (pre waiver implementation) CCC results. The majority of CCC population scores across SFY2018 -SFY2020 surveys were higher for the CCC population than the non-CCC population. In addition, the CCC population scored higher than the non-CCC population on 9 measures in 2020. This difference was most pronounced for the *Shared Decision Making*, *Coordination of Care for Children with Chronic Conditions, and Getting Needed Information* measures. Despite outperforming the non-CCC population on this measure, the *Coordination of Care for Children with Chronic Conditions* measure was the lowest performing measure in 2020 for the CCC and has been one of the lowest scoring measures since 2015, indicating continued opportunity for improvement.

Problems identified: Review of the CAHPS results did not identify a problem in need of corrective action.

Corrective action (plan/provider level): Not applicable

Program change (system-wide level): Not applicable

d. __X___ Data Analysis (non-claims)
- ___ Denials of referral requests
- _X__ Disenrollment requests by enrollee
  - _X_ From plan
  - __ From PCP within plan
- __X_ Grievances and appeals data
- ___ PCP termination rates and reasons
- __X_ Other (please describe): Care management data

Disenrollment requests by enrollee
Confirmation it was conducted as described:
- _X__ Yes
- ___ No. Please explain:

Summary of results:

ODM contracted with AHS as the independent broker for consumer enrollment and disenrollment processes. AHS required all new employees to sign an attestation assuring the employee had no conflicting interests with Medicaid MCOs or any other Medicaid-related business entities. Copies of attestation forms signed by the employee and his/her supervisor are maintained by AHS for record-keeping and auditing purposes.

Consumers could enroll by telephone, online through the Medicaid Consumer Hotline website, or by completing and mailing an enrollment form to AHS. ODM monitored AHS through monthly reports that included enrollment statistics by method of enrollment (i.e., telephone call, , postal mail, website) and by enrollment type (New MCO enrollments *or* MCO to MCO) plan changes.

ODM also monitored AHS call center performance statistics. The contract with AHS requires that the monthly average speed of answer be that 80% of calls are answered within 120 seconds of the call entering the queue if <330,000 calls are received in a month. As the monthly call volume increases, the average speed of answer increases to 150 seconds for <380,000 calls received and 180 seconds for <420,000- calls received. There is currently no SLA if >420,000 calls are received in a given month. The monthly abandonment rate must not exceed 5 percent if <300,000 calls are received in a month. The monthly abandonment rate increases to 7% if <380,000 calls are received and 10% if < 420,000 calls are received. There is currently no SLA if >420,000 calls are received in a given month. Financial penalties are assessed for each month the standards are not met, with potential termination of the contract after three months of noncompliance. AHS met all call standard metrics and were not accessed compliance. The average monthly abandonment rate was 5.0%, and the average speed of answer was 2 minutes and 38seconds.

AHS conducted customer satisfaction surveys monthly and reported the results to ODM. A total of 1899 surveys were completed during SFY 2020, for a survey response rate of 12percent. The survey elicited consumer perceptions related to satisfaction with wait times, satisfaction with answers to questions, courtesy, and overall satisfaction with AHS staff and services. Possible responses to survey questions included "Great," "Good," "Fair," and "Poor," For the SFY 2020 period, AHS was rated as "Great" or "Good" an average of 95 percent of the time across all questions, indicating a high level of consumer satisfaction with AHS services.

ODM provided consumers with the opportunity to disenroll from/transition between managed care plan(s) during the November annual open enrollment period. The State notified enrolled consumers by letter of the open enrollment period and the option to transition to a different MCO. Consumers were also given the opportunity to change MCOs during the three months following enrollment. Additionally, consumers were given the opportunity to apply for a just-cause disenrollment from an MCO as required by 42 CFR 438.56.
Each MCO provided assurances that consumer disenrollments were not requested in response to an adverse change in health status, utilization of medical services, diminished mental capacity, or uncooperative/disruptive behavior due to special needs.

Problems identified: No problems identified
Corrective action (plan/provider level): No issues were at the level of corrective action
Program change (system-wide level): Program changes were not necessary

Grievances and appeals data
Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:

Summary of results: **All MCOs submitted monthly appeal and grievance files. Contract Specialist staff completed 100% review of appeals and a representative sample review of all grievance files for monitoring of timeliness, accurate coding, sufficient resolution and program compliance. Additionally, monthly reports were reviewed to track and trend by MCO and across all MCOs.**

This information is maintained online and updated each quarter and can be found online at https://www.medicaid.ohio.gov/Managed-Care/Dashboards. For SFY 2019 the program average for grievances was 13.68 per 1000 member months and for July 2018 through January 2019 the program average was 13.79. However, for grievances related to access issues, for SFY 2019 the program average was 1.00 per 1000 member months and for July 2018 through January 2019 the program average was 1.07.

The number of appeals per 1000 member months remains low with the program averages of 0.60 for SFY 2019.

On the Grievance side, no substantive issues with timeliness, accurate coding or insufficient resolution and program compliance where identified.

Problems identified: No substantive issues were identified as a result of the monthly file reviews. Some issues regarding grievance category coding were found and this continues to be resolved quickly with technical assistance to the plans. Additionally, a few plans had minor IT issues that resulted in files being submitted a few days late and a low percentage of records rejecting due to not meeting file specifications.

Corrective action (plan/provider level) Technical assistance provided to plans for issues identified. No issues were at the level of corrective action.

Program change (system-wide level) NOT APPLICABLE

e. __X___ Enrollee Hotlines operated by State

Confirmation it was conducted as described:
_X_ Yes
___ No. Please explain:

Summary of results: **The Ohio Medicaid Consumer Hotline has the responsibility for calls from all Ohio Medicaid consumers including enrolling eligible consumers into Ohio's five managed care plans. The Hotline refers managed care issues to the Ohio Department of Medicaid Managed Care Contract Administration Unit. Contract Administration works with the MCO to resolve the issue. The Hotline logs all issues in their contact management system. Please note, the issues below were not tracked by specific population.** During calendar year2020, 4764 issues were received: 1435from managed care members and 3269 from managed care providers. Issues reported by members pertained to:

Behavioral Health Access (2 issues)
Billing (211issues)
Care Management (44 issues)
Caseworker Assistance (22 issues)
Dental Access (36 issues)
Dissatisfaction with Provider (16issues)
Eligibility (207issues)
Enrollment Verification (271 issues)
ID Card (76issues)
MCO Administrative (9issues)
Medical Treatment (9issues)
MITS Issue (32 issues)
Non-Panel (1issues)
ODM Assistance (66 issues)
Panel Access (19issues)
PCP Access (14issues)
Pharmacy (291issues)
Supervisor Explanation (10 issues)
Transportation (29 issues)

Issues reported by providers pertained to:

Care Coordination (18 issues)
Communication (85 issues)
Contracting (52issues)
Coverage/Service Denials (265issues)
Credentialing (68 issues)

Eligibility (137issues)
Payment of Claims (2371 issues)
Prior Authorization (273issues)

Managed Care Contract Administration worked with the managed care plans to resolve issues.
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. __ ___ Geographic mapping of provider network

h. __ ___ Independent Assessment of program impact, access, quality, and cost-effectiveness (Required for first two waiver periods)

Confirmation it was conducted as described:
_ __ Yes
_X__ No. Please explain:

Summary of results: Independent Assessment is not required.

i. __X___ Measurement of any disparities by racial or ethnic groups

Confirmation it was conducted as described:
__x_ Yes
___ No. Please explain:

ODM has adopted the U.S. Department of Health and Human Services—Office of Minority Health's definition of health disparities as "a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion"

Ohio's Managed Care Plans report several measures annually using HEDIS methodology. However, this methodology does not allow for stratification by race or ethnicity.

In 2012, with funding provided by the Centers for Medicare and Medicaid's Adult Medicaid Quality grant, ODM began developing internal capacity to stratify all measures by race and ethnicity and has SAS code that can be used for the majority of HEIS measures.

With the 2014 advent of Ohio Benefits, Ohio's online Medicaid eligibility application, the ability of county workers to ask applicants for race and ethnicity was diminished. This operational change along with federal prohibitions against requiring race and ethnicity to be submitted as part of the application process led to an increase in the percentage of Medicaid recipients for whom race and ethnicity information is missing. Comparative geographical analysis has revealed that much of the missing information is from areas of the state with large proportions of minorities. This unequal distribution of missing data across racial and ethnic groups has led to an artificial reduction in disparities when populations are compared on HEDIS measures.

Summary of results:

Race						
White						
Black or African American						
American Indian or Alaska Native						
Asian or Pacific Islander						
Ethnicity						
Hispanic or Latino						

ODM worked with the previous five MCOs and provider networks to increase the comprehensiveness of race and ethnicity data. This is necessary due to the inability to require these demographic fields as part of the Medicaid application process, which has resulted in up to 20 percent missing data. ODM has hired a full-time health equity program manager to spearhead this effort. The program manager is currently investigating alternative methods for obtaining more complete race and ethnicity data. These include: augmenting language in the online application to explain why race and ethnicity information is requested, supplementing ODM's

eligibility data with that collected by ODM-contracted managed care plans and Medicaid providers, supplementing ODM data with vital statistics birth or death certificate data, using geographic areas as a proxy for race and ethnicity, and statistical imputation for population-level comparisons.

The additional data will allow further stratification by racial and/or ethnic groups which will help refine and guide the Health Equity Strategy and will allow ODM to track progress in reducing these differences.

Programs that address health disparities by racial and ethnic group are most likely to be implemented across the Medicaid population rather than specifically for children with special healthcare needs. However further stratification by age and enrollment group can help assure that reductions in disparities are observed across the entire Medicaid population.

Corrective action (plan/provider level):
ODM has also updated the Managed Care Provider Agreement to require participation in all workgroups targeting the reduction of health disparities. This includes work targeting the improvement of race and ethnic data.

In addition to membership from each MCO, the health disparity reduction workgroups will also include representation from other groups that can inform this work. This includes having health equity representatives actively involved in ODM required improvement projects with an equity focus and having MCO representatives actively contribute to workgroups charged with determining the root cause of inequities and developing interventions to target and measures to track progress toward their resolution. This revision of the Health Equity Workgroup is to focus on work needed for change to occur and places greater responsibility on participating parties.

Program change (system-wide level):
Ohio has hired a full-time Health Equity program manager who is charged with updating the health equity strategy, assessing current and future MCP health equity related activities, and investigating strategies for improving the completeness of race and ethnicity data.

j. __X___ Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:

Summary of results:

ODM monitors the minimum network requirements for MCOs on a quarterly basis to ensure MCO compliance with network adequacy. As children move to managed care from FFS, the MCOs are provided with their historical FFS utilization. The MCOs used the data to evaluate provider networks to ensure that child waiver consumers have adequate access to needed specialties. ODM defined the following provider panel specifications in the Medicaid Managed Care Provider Agreement:

- **Primary Care Provider (PCP) patient capacity requirements**
- **Minimum number of primary care and specialist providers and hospitals required for each county**
- **At least one half of the required pediatric PCPs for each region must be certified by the American Board of Pediatrics**

MCOs continue to develop provider networks to adequately cover needed services. ODM concluded that, overall, the MCOs offered adequate access to health care providers.

All MCOs demonstrated that they covered out-of-network services if the contracted provider panel was unable to provide the covered services in a timely manner. Additionally, all MCOs covered second opinions within or outside the network at no cost to the consumer. Finally, all MCOs covered services provided by out-of-network federally qualified health centers (FQHCs) and rural health centers (RHCs).

Problems identified: **No problems identified.**
Corrective action (plan/provider level): **Each plan had minor deficiencies and was issued corrective action. The deficiencies did not cause access issues for members.**
Program change (system-wide level: Not applicable.)

k. __ _ Ombudsman

Confirmation it was conducted as described:
___ Yes
___ No. Please explain:

l. __ X___ On-site review

Confirmation it was conducted as described:
_X__ Yes
___ No. Please explain:
Summary of Results: **The SFY 2017 comprehensive review was conducted in Spring 2017. Nine of the 13 program standards evaluated during the review**

received MCO aggregated scores of 95 percent or higher, demonstrating strength in adherence to program requirements. Any element that was assigned a 'not met' rating by the EQRO required the MCO to submit a corrective action plan. In SFY 2018, all MCOs demonstrated compliance with the corrective action plan submission for the deficiencies that were identified in the SFY 2017 review. The next review is scheduled for Spring 2020.

m. _X___ Performance Improvement projects [Required for MCO/PIHP]
_X__ Clinical
_X__ Non-clinical

Confirmation it was conducted as described:
___ Yes
_x__ No. Please explain:

Over the past several years Ohio has made diligent progress in refining the MCO care management requirements. One such improvement is the movement to a rapid cycle model of improvement based on IHI quality improvement principles. Due to this revamping, Ohio delayed the first PIP until January of 2014 to align with larger statewide initiatives around reducing premature births and the related consequences of long-term disability and infant mortality. This performance project focuses on initiation and continuation of progesterone therapy among women who are at high risk of premature births. The case management can be complex and involves early identification of pregnancy, assessment of preterm birth risk, and removing administrative and social barriers to progesterone initiation and continuation.

Summary of results:

All MCOs met the validation criteria for each phase of the PIP (PIP initiation, SMART Aim data collection, intervention determination, intervention testing and PIP conclusions).

Problems identified:
No formal problems were identified based on the PIP validation criteria.

Corrective action (plan/provider level):

Program change (system-wide level):

n. __X___ Performance measures [Required for MCO/PIHP]
X Process
X Health status/outcomes
X Access/availability of care
X Use of services/utilization

X Health plan stability/financial/cost of care

X Health plan/provider characteristics
X Beneficiary characteristics

Confirmation it was conducted as described:
__X_ Yes
___ No. Please explain:

Summary of Results:

Managed care organizations are required to report measures that align with specific priorities, goals and/or focus areas of the Ohio Department of Medicaid quality strategy. Minimum performance standards are used to determine MCO noncompliance sanctions for specific measures, as applicable.

MCO performance on HEDIS measures are assessed using MCO self-reported, audited HEDIS data calculated in accordance with NCQA HEDIS technical specifications. The list of ODM CY 2020 HEDIS measures is included on the following pages in Table 1. In prior years, minimum performance standards for HEDIS measures were based on national HEDIS Medicaid benchmarks. Due to the impact of the COVID pandemic on service utilization and access to care in CY 2020, it was determined that the methodology for establishing minimum performance standards required modification. ODM will evaluate CY 2020 performance by comparing each MCO's results to the other MCO's results and identifying outliers that are statistically lower or higher than the median plan for the measure being evaluated. If an MCO has a result that is determined to be an outlier, the minimum performance standard is not met and the MCO is noncompliant for the measure and subject to non-compliance sanctions.

Table 1	
Population Stream / Quality Strategy Focus Area	**Performance Measure**
Healthy Children	Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months, Six or More Visits
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation
	General Child Rating of Health Plan, Customer Service Composite (CAHPS Health Plan Survey)
	Annual Dental Visits, Total Rate
	Childhood Immunization Status (Combo 3)
	Immunizations for Adolescents (Combo 2)
	Lead Screening in Children
	Percent of Live Births Weighing Less Than 2,500 Grams
	Chlamydia Screening in Women, Total
Behavioral Health	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	Follow-Up After Hospitalization for Mental Illness
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total
	Antidepressant Medication Management
	Follow-Up Care for Children Prescribed ADHD Medication
	Mental Health Utilization, Inpatient
	Follow-Up After Emergency Department Visit for Mental Illness
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
	Use of Opioids From Multiple Providers
Chronic Conditions	Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)
	Comprehensive Diabetes Care – HbA1c Testing
	Comprehensive Diabetes Care - Eye Exam (Retinal) Performed
	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)

Problems identified: The CY 2020 results indicate that one MCO was noncompliant with the standard for two rates (Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%) and CAHPS Survey-Child Customer Service Composite) and another MCO was noncompliant with the standard for two rates (Follow-up After Hospitalization for Mental Illness,7-day follow-up, ages 18-64 and CAHPS Survey-Child Customer Service Composite). Three of the five MCOs were compliant with the standard for all rates. Out of 165 reported HEDIS rates (i.e. 33 total rates for 23 measures reported for each of the five MCOs) for CY 2020, a total of four results did not meet the standard. No systemic problems were identified. It should be noted that improving diabetes outcomes is a focus for the quality withhold financial incentive program for CY 2021 and MCOs have been monitoring performance on diabetes measures in order to meet related CY 2021 quality withhold performance targets. It is expected that improved performance related to the quality withhold initiative will be reflected in the CY 2021 performance measures and compliance with standards. Of the two non-HEDIS CY 2020 performance measures, all MCOs met the standard for the Tobacco Use: Screening & Cessation Intervention measure. The CY 2020 Low-Birth Weight measure results were not available at the time this document was submitted. Performance for future measurement periods will also be monitored to determine status of refundable monetary sanctions and the assessment of progressive sanctions for instances of ongoing noncompliance (i.e. multiple, consecutive instances of noncompliance with a performance standard(s)).

Corrective action (plan/provider level): Not applicable.

Program change (system-wide level): Not applicable.

Financial performance measures:

Confirmation it was conducted as described:

_X__ Yes
___ No. Please explain:

Summary of results: **The MCOs stability/financial/cost of care measures are on an ongoing basis. Four of the five MCOs met the four financial performance measures, as calculated utilizing National Association of Insurance Commissioners (NAIC) submissions to the Ohio Department of Insurance (ODI), for CY 2019 and all five plans met them for CY 2020.**

The CY 2020 MLR, as prescribed by CMS, will not be known until December of 2021.

Problems identified: Not applicable
Corrective action (plan/provider level): Not applicable
Program change (system-wide level): Not applicable

o. ____ Periodic comparison of number and types of Medicaid providers before and after waiver

p. ____ Profile utilization by provider caseload (looking for outliers)

q. ____ Provider Self-report data
___ Survey of providers
___ Focus groups

r. _____ Test 24 hours/7 days a week PCP availability

s. _____ Utilization review (e.g. ER, non-authorized specialist requests)

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:
Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.4 and 438.5 and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual

Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances:
James Moore, Chief Financial Officer, Ohio Department of Medicaid
Telephone Number:+ 1-614-752-5392

d. E-mail:James.moore@medicaid.ohio.gov

e. The State is choosing to report waiver expenditures based on
√ date of payment.
__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a._X__ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.B**.

a. √ MCO
b. ___ PIHP
c. ___ PAHP
d. ___ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
   1. ___ First Year: $____ per member per month fee
   2. ___ Second Year: $____ per member per month fee
   3. ___ Third Year: $____ per member per month fee
   4. ___ Fourth Year: $____ per member per month fee

b. ___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d. ___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.
For Initial Waivers only:

a.__ Population in the base year data
   1._ Base year data is from the same population as to be included in the waiver.
   2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c._ _ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

d. _ _ [Required] Explain any other variance in eligible member months from BY to P2:

e._ _ __ [Required] List the year(s) being used by the State as a base year: If multiple years are being used, please explain:_____

f._ _ __ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period

g._ _ __ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

For Conversion or Renewal Waivers:

a._ √ __[Required] Population in the base year and R1 and R2 data is the population under the waiver. We have included actual member months for the SSI-Child, MAGI-Child, and MAGI-Chip populations. Based on the time periods for R1 and R2, all of these populations would have been included under the waiver during that time.

b._ √ _ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period. Note: the State utilized actual data through 9/30/2019.*

c. _√__[Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: _**The MM increase over time is consistent with historical increases in this population and also consistent relative to the population growth of the State of OH in total.**

_____

d. _√_ [Required] Explain any other variance in eligible member months from BY/R1 to P2: _ **Expenditures reported on the CMS64.21U worksheets are fully allocated to the SSI-Child and MAGI-Child based on the historical enrollment and monthly capitation payments.**

e. _√__Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: SFY_ State fiscal year ____.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a._ _ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a._ √__[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: __

b._ √_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: __**Services that will not be the responsibility of the managed care organizations (MCOs) or will not be impacted by the MCO providers were excluded from the cost effectiveness calculations.**

Medicaid children in the Ohio Home Care 1915(c) waiver program (excluding those in Group VIII) are not eligible for managed care enrollment and therefore the costs associated with these children in this program are not relevant for the cost effectiveness calculations.

G. Appendix D2.A - Administration in Actual Waiver Cost

_√___ [Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Total			

The allocation method for either initial or renewal waivers is explained below:

a._√_ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

Administrative costs reported in Appendix D2.A are based on administration that reported on the CMS 64.10 Waiver form

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

a._√__ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
Respite	*$0 PMPM*	*N/A for P1 and 5% for P2*	*$0.68 PMPM in P1 and $0.72 PMPM in P2*
Total	***No expenditures to report based on lack of utilization***	***N/A for P1 and 5% for P2***	***$0.68 PMPM x 15,253,829 = $10,372,604 in P1 and $0.72 PMPM x 15,499,362 = $11,159,541 in P2*** ***(PMPM in Appendix D5 Column Y x projected member months should correspond)***

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c._√_ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1._√_ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2.___ The State provides stop/loss protection (please describe):

d._√__Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1._√_ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.
   i. Document the criteria for awarding the incentive payments.
   ii. Document the method for calculating incentives/bonuses, and
   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

The State will withhold the specified percentage for the applicable SFY payout determination for use in the Quality Withhold Program. The State will use Quality Indices to calculate the amount of the withhold payout. Details regarding this program can be found within the provider agreement in Appendix O. The State will use the MCOs' self-reported audited HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program. Each year the State evaluates the MCOs' performance from the prior year. The current provider agreement can be found at https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans**.**

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some

states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.__ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The average annual trend rate used is. Please document how that trend was calculated:

2.__ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) *(i.e., trending from present into the future)*.

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.__ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.__ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.__ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

v.__ Other (please describe):
A.__The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment has been provided separately for each applicable change.
B.__The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.__Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.__Other (please describe):

c. __ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.__ No adjustment was necessary and no change is anticipated.
2.__An administrative adjustment was made.
i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

A.___Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.___Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.___Other (please describe):

ii.___ FFS cost increases were accounted for.
A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**.

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a**

_____

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.

2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.
Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1.___ No adjustment was necessary
2.__Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
   i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
   ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.__ We assure CMS that DSH payments are excluded from base year data.
2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. _ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2.__This adjustment was made:
   a. ___Potential Selection bias was measured in the following manner:
   b.___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.__We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2.__We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3.__***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***

4.__Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:
The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	**Capitated Program**	**PCCM Program**
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1. __ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
2. __ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
3. __ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1. __ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2. __ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.

- ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
  1. ____No adjustment was made.
  2. ____This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. _√__**State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the

waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. _√_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is:

_Actual State Plan trend is 15.0% for the SSI-Child MEG, 33.6% for the MAGI-Child MEG and 16.1%% for the MAGI-CHIP MEG Please document how that trend was calculated: Calendar Year 2020 capitation rates for the ABD-Children rate cell were utilized to establish actual trend rates for the SSI-Child MEG, while the distribution of children eligible for this waiver was utilized to establish the percentage increase in CY 2020 rates for the CFC population to calculate the actual trend rate for MAGI-Child and MAGI-CHIP rates. As the retrospective experience was from CY 2019, the actual trend increase is reflected in state Plan Cap Rate Change column noted in Prospective Year 1 on tab D5.

_√___ State historical cost increases. Please indicate the years on which the rates are based: _ *A 1% adjustment is being applied to prospective year 1 to reflect estimated changes at January 1, 2021, which would only be effective in P1 for 3 months. The 4.0% adjustment reflected for P2 reflects the residual increase for CY 2021 along with a projected increase at January 1, 2022.* _ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. *Predicted inflation trend is based on historical capitation rate changes for the Medicaid program and were not developed based on specific mathematical methodologies. No changes were accounted for other than utilization and cost.*

ii. _√__ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used ___*see list below*_____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

The applied increases were developed in consideration of historical capitation rate changes for the Medicaid managed care program in Ohio and the state's actuary's professional experience in working with other state Medicaid programs, as well as financial and encounter information from the MCOs.

If later emergence of Ohio experience for these MEGs is materially different than expected here, or if other relevant environmental patterns cause future rate development trends to differ significantly from those utilized here, the State will amend the waiver projections accordingly.

3._NOT APPLICABLE_ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __X__ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)

- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2._√__An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

vi.__ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____Other (please describe):

E.____An adjustment is included for the impact of the 1634 transition that took effect during the current waiver period, but is not fully reflected in the retrospective period data. An adjustment is being shown to account for transition of all SSI children to the ABD-Child population and ensure filed costs are consistent with capitation rates paid for that population.

F.____An additional adjustment is noted for the expansion of the behavioral health respite benefit. Based on expanded eligibility requirements for this service, the MAGI-Child and MAGI-CHIP MEGs are included under this waiver. Costs reflected in P1 for state plan are consistent with capitation rates paid for the impacted populations, which are outside of the ABD-Child population.

c. _√_ Administrative Cost Adjustment: This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver

for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2._√_ An administrative adjustment was made.
   i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
   ii._√_ Cost increases were accounted for.
      A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
      B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
      C._√__State Historical State Administrative Inflation. The actual trend rate used is: __ *3.0% for P1 and P2*_____. Please document how that trend was calculated: *Adjustments are based on review of historical administrative cost inflation trends observed for this waiver and within the Medicaid marketplace.*
      D.____Other (please describe):

   iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

      A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. _√_ **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1._√_ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present)*. The actual documented trend is: ___N/A_____. Please provide documentation.

2._√_ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_ *The base year for the behavioral health respite costs are the amount of funding included in the CY 2018 ABD Children and CFC capitation rates.*

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

Projected costs for the behavioral health respite benefit are based on costs included in the capitation rates for CY 2020 for these services. We did not increase the respite benefit funding in CY 2020 consistent with remaining services, therefore we have utilized the inflationary trends of 1% for P1 and 4% for P2 for the (b)(3) services and not the cap rate changes for CY 2020.

1. ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _ *1.0% for P1, 4.0% for P2*

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**.

_____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.

♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:
Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.
Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

A program adjustment is noted for 1915(b)(3) services (Respite services) to acknowledge the expansion of respite services to the MAGI children MEGs. This change reduced the PMPM value allocated to the SSI MEGS and added cost to the MAGI children MEGs

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

   c._√__[Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: _Changes and updates in the member month projections stem from a review of historical experience.

   d. _√_ [Required] Explain any other variance in eligible member months from BY/R1 to P2: _

   _ : *The State's actuary used actual data for the SSI-Child and MAGI-Child MEGs based on CMS-64.9 Waiver Forms with information from the CMS-64.21U Waiver Forms for the MAGI-CHIP MEG. We have not projected any material changes in member months from the retrospective and prospective years outside of general enrollment trend of 0.40% per quarter.*

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

   The applied increases were developed in consideration of historical capitation rate changes for the Medicaid managed care program in Ohio and the State's actuary professional experience in working with other state Medicaid programs, as well as financial and encounter information from the MCOs. If later emergence of Ohio experience for these MEGs materially differs from these projections, or if other relevant environmental patterns cause future rate development trends to differ significantly from those utilized here, the State will amend the waiver projections accordingly.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

NOT APPLICABLE

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.