

**Attachment B**  
**MetroHealth Care Plus Benefit Coverage**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**  
**SPECIAL TERMS AND CONDITIONS**

**NUMBER:** 11-W-00282/5

**TITLE:** MetroHealth Care Plus

**AWARDEE:** Ohio Office of Medical Assistance

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for Ohio’s section 1115(a) Medicaid MetroHealth Care Plus demonstration (hereinafter “demonstration”). The parties to this agreement are the Ohio Office of Medical Assistance (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, through December 31, 2013, unless otherwise specified.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility
- V. Benefits
- VI. Cost Sharing
- VII. Delivery Systems
- VIII. General Reporting Requirements
- IX. General Financial Requirements
- X. Monitoring Budget Neutrality
- XI. Evaluation of the Demonstration
- XII. Schedule of State Deliverables During the Demonstration Extension Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A.	Quarterly Report Content and Format
Attachment B.	MetroHealth Care Plus Benefit Coverage
Attachment C.	Funding and Reimbursement Protocol
Attachment D.	Administrative Cost Claiming Rules and Protocol

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

The Ohio MetroHealth Care Plus section 1115 demonstration provides comprehensive health care benefits to up to 30,000 uninsured adults, ages 19 through 64 years, who have family

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income at or below 133 percent of the Federal Poverty Line (FPL), who are not otherwise eligible for comprehensive Medicaid benefit coverage under the Medicaid state plan or Medicare, and reside in Cuyahoga County. The non-federal share of demonstration expenditures will be funded through a certified public expenditure by The MetroHealth System (MetroHealth).

The demonstration population will receive health care benefits through MetroHealth and community partners that MetroHealth includes in the provider network for the demonstration.

#### **Demonstration Goals:**

The state's goals under the demonstration are to:

- Substantially reduce the uninsured rate in Cuyahoga County.
- Improve the health status and quality of care for thousands of county residents.
- Study the behavior of a segment of Ohio's uninsured population as they obtain additional health benefits.
- Expand the scope of health care services available to uninsured Cuyahoga County residents.
- Increase the number of Cuyahoga County residents who will receive benefits from a regular source.
- Invest resources to further develop and expand medical home models and care coordination.

#### **Demonstration Hypotheses:**

The state will test the following hypotheses in its evaluation of the demonstration:

- Expanding eligibility to the demonstration group will increase the number of residents with health insurance coverage in Cuyahoga County.
- Assigning everyone who enrolls in MetroHealth Care Plus to a Patient-Centered Medical Home will result in more consumer visits to a primary care provider.
- Assigning everyone who enrolls in MetroHealth Care Plus to a Patient-Centered Medical Home will result in the per member per month costs being less than they would be without assignment to Patient-Centered Medical Home.
- Assigning everyone who enrolls in MetroHealth Care Plus to a Patient-Centered Medical Home will result in quality clinical care received by those consumers enrolled in the demonstration.
- Expanding eligibility to the demonstration group will help the state identify the health status and utilization patterns of this group of individuals.

### **III. GENERAL PROGRAM REQUIREMENTS**

1. **Compliance with federal non-discrimination statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

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2. **Compliance with Medicaid law, regulation, and policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part must apply to the demonstration.
3. **Changes in Medicaid law, regulation, and policy.** The state must, within the time frames specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy statement affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
  - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in Federal Financial Participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
  - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit Title XIX state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC seven below.
7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs,

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8. including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
  - a. An explanation of the public process used by the state, consistent with the requirements of STC 16, to reach a decision regarding the requested amendment.
  - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
  - c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX state plan amendment, if necessary; and
  - d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

**9. Extension of the Demonstration.**

- a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph nine.
- b. Compliance with Transparency Requirements 42 CFR Section 431.412:

Effective April 27, 2012, as part of the demonstration extension requests, the state must provide documentation of compliance with the transparency requirements at 42 CFR section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 16, as well as include the following supporting documentation:

- i. Historical Narrative Summary of the Demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
- ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a

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brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. **Waiver and Expenditure Authorities:** The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. **Quality:** The state must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; state quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.

v. **Financial Data:** The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. **Evaluation Report:** The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. **Documentation of Public Notice 42 CFR section 431.408:** The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

**10. Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft

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phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- b. **Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
  - c. **Phase-out Procedures:** The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
  - d. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
11. **Post Award Forum.** Within 6 months of the demonstration's implementation, and annually thereafter for the duration of the demonstration, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraphs 37 and 38 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 39.

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12. **The CMS Right to Terminate or Suspend.** The CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
13. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.
14. **Withdrawal of Waiver Authority.** The CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
15. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
16. **Submission of Transition Plan Related to Implementation of the Affordable Care Act.** On January 1, 2014, expenditure authority for the demonstration expansion population will expire. The state is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a health coverage option. The state must submit a draft to CMS by August 1, 2013, with progress updates included in each quarterly report. The state will revise the Transition Plan as needed.
17. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

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In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

18. **FFP.** No Federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

#### **IV. ELIGIBILITY**

19. **Eligibility Criteria.** Demonstration eligibles are uninsured individuals who:

- a. Are adults age 19 through 64 years who are not pregnant;
- b. Are screened and found not eligible for comprehensive Medicaid benefits under the Medicaid state plan or Medicare;
- c. Have family income at or below 133 percent of the FPL, or an equivalent standard using a modified adjusted gross income-based (MAGI-based) income determination methodology;
- d. Reside in Cuyahoga County; and
- e. Are U.S. citizens, nationals, or qualified non-citizens.

20. **Eligibility Determinations.** Eligibility determinations for the demonstration-eligible population are determined based on an application by the beneficiary, except that individuals previously enrolled in the Hospital Care Assurance Program (HCAP) will be automatically enrolled without an additional application, based upon their application to HCAP, to the extent that they are determined to be citizens, nationals, or qualified non-citizens within 60 days of enrollment. Demonstration-eligible individuals may initiate application for the demonstration by phone, online, mail or at any MetroHealth site. The MetroHealth eligibility intake staff must screen applicants for Medicaid prior to enrollment into the demonstration.

If found eligible and there is no waiting list in place, the individual will be enrolled into the demonstration and offered coverage as outlined below in sections V and VII of the STCs. If found eligible and there is a waiting list in place, the individual will be notified of placement on the waiting list.

The state must ensure that demonstration applicants that meet the requirements for Medicaid under the state plan will be processed and enrolled in Medicaid as these populations are ineligible for the demonstration.

The state must provide appropriate monitoring, oversight, auditing, and training of eligibility determinations conducted by MetroHealth employees. The state must provide updates and appropriate data on the monitoring, oversight, auditing, and training activities in each quarterly report pursuant to STC 36.



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Individuals may self-attest to the eligibility criteria listed in STC 18 at the time of application. MetroHealth will work to verify eligibility electronically. If verification of any eligibility criteria cannot be obtained electronically, at the time of initial enrollment, MetroHealth must assist individuals in obtaining any documents needed to verify eligibility. If eligibility verification is not obtained by the end of that 60 day period, the individual will be disenrolled within 10 days unless MetroHealth issues a good cause exception.

Upon initial implementation of the demonstration, the state will limit enrollment to 30,000 individuals. The state will have flexibility to increase enrollment or remove the enrollment limit in accordance with the criteria outlined below. An adjustment to increase enrollment will not require an amendment to the demonstration pursuant to STC 6.

- a. Notice. Before increasing or removing this limit, the state must notify CMS at least 30 calendar days in advance of implementation and provide public notice. This notice must include updated budget neutrality spreadsheets, projected enrollment estimates, and proposed enrollment limit.
- b. Non-Federal Share. Prior to implementation of any increase in enrollment or removing the limit, the state must identify an allowable source of non-Federal share, which must be approved by CMS.
- c. Attrition. If the state chooses to implement the enrollment target, individuals enrolled at that time must be able to maintain coverage, and enrollment may only be reduced by attrition.
- d. Implementing Enrollment. A demonstration eligible individual may be placed on a waiting list for enrollment in the program if current enrollment in the program meets the current enrollment limit, if applicable.
- e. Notification to Applicants. When applicants are placed on a waiting list, they will receive notification of waiting list status. If a position for enrollment into the demonstration becomes available, the individual will receive notification of enrollment into demonstration coverage.

21. **Enrollment Threshold.** Enrollment for the MetroHealth Care Plus demonstration is subject to an enrollment threshold of 30,000 adults. The state has a target enrollment number of 30,000 adults and will seek to maintain full enrollment in the program.

22. **Wait List.** Upon reaching the target enrollment of 30,000 adults, the MetroHealth System is authorized to maintain a wait list for the MetroHealth Care Plus program. Applicants will be placed on the wait list in chronological order of the MetroHealth System's receipt of their application. The MetroHealth System will continue to screen applicants for Medicaid eligibility upon receipt of a MetroHealth Care Plus application before placing the applicant on the wait list. As enrollment space becomes available either through attrition or an increase in the target enrollment, the MetroHealth System will notify applicants on the MetroHealth Care Plus wait list, beginning with the oldest application, informing them to

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electronically verify the information the MetroHealth System has on file in its system in order to enroll them into the MetroHealth Care Plus program. The state must submit the plan for managing the wait list to CMS within 30 days after approval of the demonstration.

23. **Notice to CMS for Eligibility Determination Process Changes.** The income determination used in the demonstration will use all income of the applicant and compare the net countable family income to 133 percent of the FPL. In the future, the state may use different income counting methods for purposes of the demonstration relative to other Medicaid populations covered in the state such as using the modified adjusted gross income eligibility determination methods as described in section 1902(e)(14) for the demonstration population, to the extent the methodology does not disadvantage an individual. As the state develops its eligibility systems to make determinations based on Modified Adjusted Gross Income (MAGI), the state must notify CMS how eligibility determinations for the demonstration will be revised to use MAGI and when changes will be implemented.
24. **Eligibility Period.** An individual who meets program eligibility criteria can be determined eligible through December 31, 2013.
25. **Retroactive Eligibility.** Retroactive eligibility as provided for under the approved Medicaid state plan does not apply to demonstration eligibles.
26. **Eligibility Redeterminations.**
  - a. A demonstration enrollee may apply for eligibility under the Medicaid state plan at any time for any reason. The state must determine eligibility for Medicaid and CHIP and enroll individuals in programs for which they are found eligible, unless the individual is found eligible for a limited Medicaid benefit package and the individual chooses to enroll in the demonstration in lieu of the limited Medicaid benefit package.
  - b. As the state develops its eligibility systems to make determinations based on MAGI, redeterminations will be updated to allow for eligibility determinations as required under the Affordable Care Act.
  - c. Redeterminations for demonstration enrollees (who are found eligible in 2012) may take place after a period of greater than 12 months.
  - d. For those individuals who are found eligible in 2012, eligibility must be redetermined prior to January 1, 2014 to ensure that individuals are properly enrolled in a health coverage option beginning in January 2014. Therefore, determinations for demonstration enrollees (who are found eligible in 2012) may take place after a period of greater than 12 months. An individual would not need to be redetermined if the period is less than 12 months.
27. **Disenrollment.** Demonstration enrollees will be disenrolled based on a change in the following circumstances in accordance with Medicaid law and policy: income, residency status, eligibility for comprehensive Medicaid benefit coverage under the Medicaid state plan, eligibility for Medicare, or achieving age 65. Prior to disenrollment from the

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demonstration based on income, the state must determine if an individual is eligible under any other basis/existing Medicaid category.

**V. BENEFITS**

28. **Benefits.** Demonstration enrollees must receive all approved demonstration services, listed below. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Service limitations are detailed in Attachment B, “MetroHealth Care Plus Benefit Coverage.”

**Services**

Inpatient Hospital Services	Occupational Therapy
Outpatient Hospital Services	Speech Therapy
Physician Services	Durable Medical Equipment
Prescription Medications	Podiatry Service
Home Care Services	Smoking Cessation
Short-term Skilled Nursing Facility Services (30 days)	Weight Management Clinic Services for Patients with BMI>30
Mental Health/Substance Use Disorder Detox Services	Medical Nutrition Counseling
Emergency Services (including Transportation)	Dental Services
Non-Emergency Medical Transportation	Care Coordination
Physical Therapy	

**VI. COST SHARING**

29. **Cost Sharing.** All demonstration enrollees will be subject to cost-sharing up to the cost-sharing levels applied under the Medicaid state plan. The state ensures that any cost-sharing will be nominal, as stipulated in 42 C.F.R 447.54. Standard Medicaid exemptions from cost-sharing, such as family planning services, as stipulated in 42 C.F.R. 447(b) apply to the demonstration.

**VII. DELIVERY SYSTEMS**

30. **Patient Centered Medical Homes.** The MetroHealth System has established Patient Centered Medical Homes to provide high-quality, coordinated care and case-management to demonstration enrollees. All individuals enrolled for the demonstration will be encouraged to elect a MetroHealth network Patient Centered Medical Home (PCMH) at the initial date of enrollment. The participant has the option, at any time, to elect a different PCMH or a different primary care provider within a different PCMH in the demonstration’s provider network. Individuals that do not have a relationship with a network PCMH Primary Care Provider (PCP) at the time of enrollment will choose their primary care provider and be assigned to the PCMH with which that PCP is affiliated. If the individual does not choose a

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PCP/PCMH at the time of initial enrollment, she/he will select the PCP at the time of their first primary care visit. The PCMH is charged with assisting individuals in coordinating care and assisting the enrollee in obtaining care that will improve health outcomes.

31. **Role of MetroHealth and its Community Partners.** MetroHealth and its community partners are charged with assisting individuals in coordinating care, improving health outcomes, and assisting enrollees in selecting a PCMH. MetroHealth manages the primary care provider network and is required to contract with community partners to ensure adequate access to PCMHs and covered benefits. In addition to managing a network of primary care providers, MetroHealth must establish a network of specialists and ancillary providers.
  
32. **Provider Reimbursement and Claims for Federal Funding.** The state is responsible for making payments to MetroHealth, which will be paid on an interim incurred cost basis. MetroHealth will be acting as a fiscal agent for the state and will be responsible for paying all providers for covered services under the demonstration. Within 6 months following the end of calendar year 2013, MetroHealth must submit preliminary cost reports to the state detailing the actual cost of furnishing covered services, consistent with OMB and Medicare cost reporting principles. Within 180 days after the submission of such preliminary cost reports, the state must reconcile the interim PMPM to the preliminary actual MetroHealth cost. The state must submit the findings of the cost analysis to CMS within 180 days of the submission of the cost reports and no later than December 31, 2014. Final settlement must occur within 180 days of receipt of the final Medicare cost report for MetroHealth's Ohio Medicaid Hospital Cost Report.

Allowable service costs for MetroHealth include only costs for demonstration benefits furnished to demonstration eligibles that are provided either directly by MetroHealth itself or by primary care providers, specialists, and ancillary providers that have contracted to be a network provider within the MetroHealth network or by non-network providers rendering emergency medical services.

To the extent that MetroHealth includes FQHCs in its network, FQHCs must be reimbursed consistent with §1902(bb)(5) of the Social Security Act. MetroHealth may also include the costs it incurs for outstationed eligibility staff and these costs must be claimed at the administrative services matching rate of 50 percent.

If the expenditures reported by MetroHealth on the preliminary cost report exceeded the interim payment rate, the state must immediately credit the federal government with the federal share of such excess. In addition, if the expenditures determined in the state's final cost analysis of the preliminary cost report exceed the amount reported on the preliminary cost report, after completion of the final cost analysis, the state must immediately credit the federal government with the federal share of such excess. Within 180 days of the final Medicare cost report for MetroHealth's Ohio Medicaid Hospital Cost Report, MetroHealth should submit and have approved by the state a final clean cost report based on the state's final cost analysis, and the state must properly credit the federal share of any amounts not supported by the state-approved final cost report.

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If expenditures claimed by MetroHealth were understated and there are no budget neutrality restrictions, after making payment to MetroHealth, the state may draw down the federal share of any such payments from the federal government.

Additional detail regarding provider reimbursement and claims for federal funding can be found in Attachment C: Funding and Reimbursement Protocol.

33. **Network Requirements.** The state must ensure the service delivery system is sufficient to provide enrollees with access to all covered benefits. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Services must be delivered in a culturally competent manner and consistent with all requirements under the Americans with Disabilities Act, and all requirements related to serving individuals with limited English proficiency. If a demonstration participant needs a service that is outside the demonstration benefit package, the provider must educate the demonstration participant on where s/he may receive the service. Providers must refer the demonstration enrollee to other providers to assure benefits can be received.

At minimum, reasonably prompt access to care must include:

- a. Medically necessary services available 24 hours a day, 7 days per week;
  - b. Access to primary health care services will be provided at a location within 15 miles from each enrollee's place of residence;
  - c. Primary care appointments will be available within 30 business days of the request during the term of the demonstration;
  - d. Urgent primary care appointments will be provided within 48 hours or 96 hours if prior authorization is required; and
  - e. Specialty care access will be provided at a minimum within 30 business days of the request.
34. **Demonstrating Network Adequacy.** The state must provide updates on the MetroHealth network including community partners in each quarterly report, consistent with the requirements of STC 37. Every 6 months, each MetroHealth network provider must provide adequate assurances that it has sufficient capacity to serve the expected enrollment.
35. **Delivery System and Access to Care Monitoring.** The state and MetroHealth must monitor and evaluate the sufficiency of the MetroHealth delivery system for demonstration enrollees including the need for and access to comprehensive health care services at both the MetroHealth facilities and their community partners. Monitoring activities must be reported quarterly (within 45 days of the ending of the calendar quarter) and must include:
- a. A tracking of demonstration enrollee volumes at all MetroHealth and community partner facilities including a comparison to historical volumes; and,
  - b. A reporting of clinic wait times for primary care, physician specialty care, and outpatient services.

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**VIII. GENERAL REPORTING REQUIREMENTS**

36. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX set forth in section IX of these STCs.
37. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in section X of these STCs.
38. **Quarterly Calls.** The state must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MetroHealth operations (such as network adequacy, training of eligibility and enrollment staff, assignment of a PCMH, contract amendments, and rate certifications), health care delivery, enrollment, proposed or implemented changes to the enrollment limit and/or state-specified income eligibility standard, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes in payment rates, MetroHealth and community partner financial performance that is relevant to the demonstration, role of the evaluators progress, state legislative developments, any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.
39. **Quarterly Reports.** The state must submit progress reports in the format specified in Attachment A. No later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:
- a. An updated budget neutrality monitoring spreadsheet;
  - b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, MetroHealth and community partner operations (such as network adequacy, training of eligibility and enrollment staff, assignment of a PCMH, contract amendments and rate certifications); health care delivery; benefits; enrollment; grievances; quality of care; access; proposed changes to payment rates; proposed or implemented changes to the enrollment limit and/or state-specified income eligibility standard; pertinent legislative activity; and other operational issues;
  - c. Action plans for addressing any policy and administrative issues identified;
  - d. Quarterly enrollment reports that include the member months, in addition to end of quarter and point-in-time enrollment for each demonstration population and other statistical reports listed in Attachment A;

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- e. Comparison of the demonstration enrollees actual PMPM costs with the projected PMPM costs of the approved proposal.
  - f. Updates on improvements to the MetroHealth provider network and community partners as stipulated in STC 29;
  - g. Updates on the number of demonstration enrollees who have been enrolled into a PCMH;
  - h. Updates on the state's monitoring, oversight, auditing, and training of eligibility determinations conducted by MetroHealth employees as specified in STC 19. These updates must include information describing any corrective actions taken, or changes to the policy that were made as a result of the monitoring and oversight activities, and identification and description of the issue that the corrective action is intended to address. The updates must also include data from the eligibility quality control procedures.
  - i. Updates regarding the availability of non-federal share;
  - j. Data on the number of individuals who are disenrolled for lack of income verification documents each quarter, and as a share of total enrollees during that quarter;
  - k. Progress updates to the Transition Plan as specified in STC 15, and
  - l. Evaluation activities and interim findings.
40. **Annual Report.** The annual report must include, at a minimum, the requirements outlined below. The state must submit the draft annual report no later 120 days after the close of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
- a. All items included in the quarterly report pursuant to STC 41 must be summarized to reflect the operation/activities throughout the DY;
  - b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and
  - c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement.
41. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

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**IX. GENERAL FINANCIAL REQUIREMENTS**

42. **Quarterly Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section IX of the STCs.
43. **Reporting Expenditures under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
- a. Tracking Expenditures. In order to track expenditures under this demonstration, Ohio must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).
  - b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
  - c. Premium and Cost Sharing Contributions. Applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64Narr by demonstration year.
  - d. Pharmacy Rebates. Providers under this demonstration are participants in the 340B program; therefore, pharmacy rebates will not apply to the demonstration.
  - e. Use of Waiver Forms. For each demonstration year, a separate Form CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name "Adults" to report expenditures for the demonstration population. The waiver name "Adults" must be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver expenditures should be allocated to these forms based on the guidance found below.



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44. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures related to the demonstration benefit package described in Section V of the STCs provided to individuals who are enrolled in this demonstration as described in Section IV of the STCs. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.
45. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
46. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap must be made within 2 years after the conclusion or termination of the demonstration. During the 2-year period following the conclusion or termination of the demonstration, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
47. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:
- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 41, the actual number of eligible member months for the demonstration population. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.  
  
To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
  - b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
48. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. Ohio must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made

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in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

**49. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section X of the STCs:

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Net medical assistance expenditures made under section 1115 demonstration authority.

**50. Sources of Non-Federal Share.** The state must certify that matching the non-Federal share of funds for the demonstration are state/local monies derived from state or local tax revenue. The state further certifies that such funds must not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. The CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-Federal share of funding.
- c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

**51. State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must

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approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.
- e. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

52. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

53. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the demonstration.

**X. MONITORING BUDGET NEUTRALITY**

54. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of Federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS's assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

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55. **Risk.** Ohio shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles. Because CMS provides FFP for all demonstration eligibles, Ohio shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Ohio at risk for the per capita costs for current eligibles, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

56. **Demonstration Population Used to Calculate the Budget Neutrality Expenditure Cap.** The following describes the method for calculating the budget neutrality expenditure cap for the demonstration:

- a. For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group (EG) described as follows:
  - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 46 for the demonstration population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (ii) below.
  - ii. The PMPM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility group subject to the budget neutrality agreement under this demonstration are specified below. A PMPM was constructed based on state historical expenditure data. The trend rate and PMPM amounts for the demonstration population are shown below. The demonstration population is a “pass-through” or “hypothetical” population. Therefore, the state may not derive savings from this population.

Eligibility Group	DY 1 (Date of approval letter through 12/31/2013) PMPM
Adults	\$582.41

- iii. The annual budget neutrality expenditure cap for the demonstration as a whole is the sum of the projected annual expenditure cap for the demonstration population calculated in subparagraph (i) above.
- b. Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the extension approval period, as reported on the forms listed in STC 42(e) above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

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- c. The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a)(iii). The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration population described in STC 42(e) during the demonstration period reported in accordance with STC 42.

**57. Future Adjustments to the Budget Neutrality Expenditure Limit.** The CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

**58. Enforcement of Budget Neutrality.** The CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

<u>Demonstration Year</u>	<u>Cumulative Expenditure Cap Definition</u> <u>Percentage</u>
Year 1	Budget neutrality expenditure cap plus 0 percent

**59. Exceeding Budget Neutrality.** If, at the end of this demonstration period, the cumulative budget neutrality expenditure cap has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

**XI. EVALUATION OF THE DEMONSTRATION**

**60. Submission of Draft Evaluation Design.** The state shall submit to CMS for approval within 120 calendar days from the award of the demonstration extension a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

- a. Domain of Focus. The Evaluation Design must, at a minimum, address the research questions/topics listed below and the goals of the demonstration as outlined in

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Section II of the STCs. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.

- i. The impact of the demonstration in covering the uninsured in the County, including the estimated numbers of eligible uninsured individuals who did and did not enroll in the demonstration;
- ii. The number of demonstration-enrolled individuals accessing health care services in comparison to the number of demonstration eligibles in need of services;
- iii. The state must address the following evaluation questions and topics in the draft evaluation plan:
  1. How has the demonstration bridged the gap in Medicaid coverage in the low income population;
  2. How has the demonstration addressed unmet healthcare needs and provided a regular source of coordinated care for enrollees;
  3. How has the demonstration influenced health seeking behavior in a manner that could help manage costs;
  4. How has the demonstration informed the state's progress in understanding the service utilization and costs of the uninsured;
  5. How effective have the PCMHs been in providing high-quality, coordinated care? (The state must propose quality measures that would be used to evaluate the effectiveness of the PCMHs);
  6. What is the impact on enrollment of eligible individuals of using alternate methods, other than through electronic data matches, for verifying social security numbers and income?
- iv. The limitations, challenges, opportunities and best practices in provider capacity and care delivery for the demonstration population.
- v. An analysis of service utilization and trends identified over time;
- vi. The decrease in uncompensated care provided by hospitals and federally qualified health centers (FQHCs) serving individuals who would have received discounted medical services through the MetroHealth in the absence of the demonstration;
- vii. The number of demonstration-enrolled individuals who would have received discounted medical services through MetroHealth participating hospitals and FQHCs in the absence of the demonstration;
- viii. The cost-effectiveness and efficiency of the demonstration program in ensuring that appropriate health care services are provided in a cost-effective and coordinated fashion;
- ix. Provider network capacity to serve the health care needs of the demonstration population; and
- x. Trends in beneficiary needs for the demonstration population.

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61. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of its request for each subsequent renewal.
62. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design described in STC 59 within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.
63. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the demonstration; the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

**XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD**

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

<b>Date - Specific</b>	<b>Deliverable</b>	<b>STC Reference</b>
120 days from date of award letter	Submit Draft Evaluation Plan	STC 59
60 days of receipt of CMS comments	Submit Final Evaluation Plan	STC 61
08/01/2013	Submit Draft Transition Plan	STC 15
<b>Annually</b>	<b>Deliverable</b>	<b>STC Reference</b>
120 days after the close of the DY	Draft Annual Report	STC 39
30 days following receipt of CMS comments	Final Annual Report	STC 40
<b>Each Quarter</b>	<b>Deliverable</b>	<b>STC Reference</b>
60 days after the close of the quarter	Quarterly Operational Reports	STC 38
60 days after the close of the quarter	CMS-64 Reports	STC 41

Under STC 38, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

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The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook will be provided.

**NARRATIVE REPORT FORMAT:**

**Title Line One** – MetroHealth Care Plus

**Title Line Two - Section 1115 Quarterly Report**

**Demonstration/Quarter Reporting Period:**

Example:

Demonstration Year: 1 (Date of approval letter through 12/31/2013)

Federal Fiscal Quarter: 2 (Date of approval letter through 03/31/2013)

**I. Introduction**

Information describing the goals of the demonstration, what it does, and the key dates of approval/operation. (This should be the same for each report.)

**II. Enrollment Information**

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by “0”.

**A. Enrollment Counts**

**Note:** Enrollment counts should be person counts, not member months

<b>Demonstration Populations (as hard coded in the CMS 64)</b>	<b>Current Enrollees (to date)</b>	<b>Disenrolled in Current Quarter</b>
<b><u>MetroHealth Care Plus</u></b>		

**B. Enrollment**

Summarize what the current enrollment within the demonstration.

**C. Collection and Verification of Encounter Data and Enrollment Data**

Summarize any issues, activities or findings related to the collection and verification of encounter and enrollment data.

**III. Benefits Information**

Discuss any changes or anticipated changes in populations served and benefits, including any implemented or proposed changes to the state plan benefits or covered mental health diagnosis for eligible individuals to receive behavioral health services.



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**IV. Assignment of a Primary Care Medical Home**

Summarize MetroHealth activities related to assignment of new enrollees to a PCMH and complete the following chart:

<b>Demonstration Populations</b>	<b>New Enrollees for the Quarter</b>	<b>New Enrollees Who Choose a PCMH</b>	<b>New Enrollees Assigned to a PCMH</b>
<b><u>MetroHealth Care Plus</u></b>			

**V. Updates on Additional Community Partners**

Provide a list of any additional Community Partners that have joined the demonstration delivery system.

**VI. Outreach/Innovative Activities**

Summarize outreach activities and/or promising practices for the current quarter.

**VII. Operational/Policy Developments/Issues**

Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, MetroHealth operations (such as network adequacy, assignment of a PCMH, contract amendments and rate certifications); approval and contracting with new plans; health care delivery; benefits; enrollment; grievances; quality of care; access; proposed changes to payment rates; proposed or implemented changes to the enrollment limit and/or state-specified income eligibility standard; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; and other operational issues.

Summarize the development, implementation, and administration of any action plans for addressing issues related to the demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

Provide any updates on the state’s monitoring, oversight, auditing, and training of eligibility determinations conducted by MetroHealth employees.

Provide updates on the number of individuals who are disenrolled for lack of income verification documents.

**VIII. Budget Neutrality**

**A. Financial/Budget Neutrality Development/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state’s actions to address these issues.

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**B. Member Month Reporting**

Enter the member months for each of the EGs for the quarter.

**i. For Use in Budget Neutrality Calculations**

<b>Eligibility Group</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Total for Quarter Ending XX/XX</b>
MetroHealth Care Plus				

<b>Eligibility Group</b>	<b>Total Member Months for the Quarter</b>	<b>PMPM</b>	<b>Total Expenditures (Member months multiplied by PMPM)</b>
MetroHealth Care Plus			

**IX. Consumer Issues**

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from enrollees and consumer groups.

**X. Quality Assurance/Monitoring Activity**

Identify any quality assurance/monitoring activity in current quarter.

**XI. Demonstration Evaluation**

Discuss progress of evaluation design and planning.

**XII. Transition Plan**

Pursuant to STC 15 provide updates on the state's work related to the transition plan consistent with the provisions of the Affordable Care Act, for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of enrolled individuals to a health coverage option.

**XIII. Additional Information**

**A. Enclosures/Attachments**

Identify by title any attachments along with a brief description of what information the document contains.

**B. State Contact(s)**

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

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**C. Date Submitted to CMS**

Asterisked (\*) service categories require Prior Authorizations.

<b>Service</b>	<b>MetroHealth – Medicaid Waiver Program</b>
<b>Covered benefits require use of a MetroHealth Care Plus Network Provider</b>	The MetroHealth Care Plus Network is limited to specific providers which include The MetroHealth System’s facilities, physicians, and professional staff as well as community providers specifically contracted for participation in the MetroHealth Care Plus Provider Network. Any exceptions to allow coverage for specific patient cases by non-network providers must be approved by The MetroHealth Care Plus program. A PCP is required as are referrals from the PCP to Specialists.
<b>Allergy Testing and Treatment*</b>	Testing procedure limited to one MetroHealth Allergy Specialist Visit and requires MetroHealth Care Plus Medical Director authorization. Treatment covered when rendered by MetroHealth Provider, after approved testing.
<b>Chiropractic services</b>	Not covered.
<b>Audiology services</b>	Hearing Aids not covered. Audiology/Hearing Test not covered unless the hearing loss is the result of a medical injury. Chronic/progressive loss of hearing related to aging is not a covered benefit.
<b>Dental services*</b>	One exam and cleaning every 12 months covered if rendered by MetroHealth Dental Clinics. Fillings, extractions, anterior crowns, and root canals covered only when approved by MetroHealth D.D.S. and rendered at a MetroHealth facility. Orthodontia, implants, other crowns, dentures cosmetic procedures, and other major services not covered.
<b>Optometry and ophthalmology services</b>	Exam (routine refraction), eyeglasses, and contact lenses not covered. Glaucoma screening covered as preventive care when rendered by MetroHealth Care Plus Provider. Diabetic retinal exams by MetroHealth Care Plus Provider covered with (referral required).
<b>Physical therapy, occupational therapy, and speech/language pathology services*</b>	Rehabilitative Services require MetroHealth Care Plus Medical management approval and must be rendered by MetroHealth Care Plus Provider. Number of visits to be authorized as covered benefits is based on the patient’s condition and MetroHealth medical management authorization.
<b>Developmental therapy</b>	Not covered.
<b>Urgent Care</b>	Urgent care is covered only when rendered at MetroHealth’s Express Care facilities.

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<b>Services</b>	<b>MetroHealth – Medicaid Waiver Program</b>
<b>Transportation*</b>	Non-emergency transportation provided by MetroHealth vans to and from MetroHealth facilities only where services provided. Ambulance for covered emergency transport based on “911” call. Wheelchair van and non-emergency medically necessary ambulance transport (MetroHealth prior authorization required).
<b>Diabetic Supplies and Insulin*</b>	All diabetic supplies covered with limits on quantity supplied by MetroHealth Care Plus Providers. Insulin pump and glucometer covered with MetroHealth Care Plus Medical management approval and supplied by MetroHealth Care Plus Providers.
<b>Dietitian Services*</b>	Coverage for Medically necessary services by MetroHealth Care Plus Provider as needed for those patients with a diagnosis of diabetes, kidney disease, hyperlipidemia, hypertension, and heart failure, and upon MetroHealth Care Plus medical management approval for other diagnoses.
<b>Durable medical equipment (DME) &amp; Devices*</b>	<p>Covered Devices from MetroHealth Care Plus providers include:</p> <ul style="list-style-type: none"> <li>• Implantable cardioverter defibrillators</li> <li>• Pacemakers</li> <li>• Coronary &amp; vascular stents</li> </ul> <p>Covered DME items from MetroHealth Care Plus Provider include:</p> <ul style="list-style-type: none"> <li>• Wheelchairs - requires MetroHealth Care Plus physician referral to MetroHealth Wheelchair Clinic and prior authorization for wheelchair acquisition from MetroHealth Care Plus DME provider</li> <li>• Canes, crutches and walkers</li> <li>• Oxygen supplies</li> <li>• Ostomy supplies</li> </ul> <p>Other DME requires prior authorization from MetroHealth Care Plus Medical management for coverage.</p>
<b>Emergency Room</b>	Non-emergency use of an Emergency Room outside of the MetroHealth Care Plus not covered. Emergency room care at MetroHealth facility covered. True emergency care at facilities other than MetroHealth covered. MetroHealth Care Plus medical management will review such emergency care for EMTALA compliance. Patients needing admission or follow-up care from a non-MetroHealth ED visit will be transferred or directed to MetroHealth.

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<b>Services</b>	<b>MetroHealth – Medicaid Waiver Program</b>
<b>Healthchek (EPSDT)</b>	Not covered.
<b>Preventive Exams and Screenings</b>	Preventive exams and screenings including PAP tests, skin exams, prostate cancer screenings, mammograms, colorectal screening covered when rendered or referred to MetroHealth as part of annual health exam by MetroHealth Care Plus Provider.
<b>Immunizations</b>	Vaccines as recommended by the Centers for Disease Control (HPV, Zoster, Tetanus, Pneumonia and Influenza) covered when rendered by MetroHealth Care Plus Provider.
<b>Laboratory and X-ray services*</b>	Medically necessary lab and x-ray services ordered by a MetroHealth Care Plus Provider covered when rendered at MetroHealth facility. Mammograms at MetroHealth covered when ordered by MetroHealth Care Plus Provider as a medically necessary service.
<b>Home health services*</b>	Skilled home health nursing, physical therapy, occupational therapy, and speech pathology are covered with prior authorization from MetroHealth Medical management for coverage.
<b>Private duty nursing services</b>	Not covered.
<b>Home and community-based services (e.g., PASSPORT, Ohio Home Care, Individual Options and Assisted Living waivers)</b>	Not covered.
<b>Hospice services</b>	Not covered.
<b>Inpatient hospital services*</b>	Services provided at MetroHealth facility covered
<b>Outpatient hospital services*</b>	Outpatient Services, Ambulatory Surgery, Extended Recovery, and Observation provided at MetroHealth facilities covered.
<b>Physician services</b>	Services provided by MetroHealth Care Plus providers covered, including but not limited to MDs, DOs, NPs, PAs, CRNAs, RNs, SWs. MetroHealth specialist services require a referral from MetroHealth Care Plus PCP.
<b>FQHC Services</b>	Covered outpatient services provided by contracted providers within The MetroHealth Care Plus Network.
<b>Family planning services and supplies</b>	Covered when rendered by MetroHealth Care Plus Provider.
<b>Podiatry services*</b>	Referrals to MetroHealth Care Plus providers for medically necessary podiatry care approved. Routine foot care consults limited to patients with neurovascular diagnoses, including diabetes at frequency of 2 referrals per year.
<b>Prosthetics and Orthotic</b>	Not covered.

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**MetroHealth Care Plus Benefit Coverage**

<b>Nursing facility (NF) services*</b>	Short-term skilled nursing and acute rehabilitation when medically necessary following a MetroHealth service covered when approved by MetroHealth Care Plus Medical Management. Limited to 30 days per calendar year.
<b>Intermediate Care Facility for persons with Mental Retardation (ICF/MR) services</b>	Not covered.
<b>Community Behavioral Health Services*</b>	Mental Health and Substance abuse services require MetroHealth Care Plus network physician referral for coverage. Services include: <ul style="list-style-type: none"> <li>• Behavioral health counseling</li> <li>• Mental health assessment</li> <li>• Pharmacologic management</li> <li>• Crisis intervention</li> <li>• Community psychiatric support treatment</li> <li>• Intensive outpatient treatment</li> <li>• Substance abuse assessment</li> <li>• Substance abuse counseling – individual, group, family</li> </ul> Acute inpatient psychiatric hospitalization.
<b>Independent psychologist services*</b>	Coverage limited to visits to MetroHealth Care Plus providers approved by MetroHealth Care Plus PCP or MetroHealth Care Plus Medical Management approved visits.
<b>Prescription drugs*</b>	Prescriptions for formulary drugs covered when filled at a MetroHealth Care Plus Network Pharmacy. Non-formulary drugs require prior MetroHealth Care Plus Medical Director review and approval. OTCs not covered.
<b>Smoking cessation services</b>	Coverage limited to group programs at MetroHealth
<b>Weight management</b>	Coverage for Clinic services rendered at The MetroHealth System limited to patients with BMI>30
<b>Alcohol and Substance Abuse-Detox</b>	Coverage limited to 3 days at a MetroHealth Care Plus facility
<b>Care Coordination</b>	Part of the Administrative Services of the MetroHealth Care Plus Program

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The state must modify this protocol as well as any portion of the approved section 1115 demonstration that utilizes certified public expenditures (CPEs) to reflect any changes in CPE regulations or policy that the Centers for Medicare & Medicaid Services (CMS) may release.

**I. SUMMARY OF OHIO MEDICAID HOSPITAL COST REPORT (JFS 02930)**  
**SCHEDULES AND STEP-DOWN PROCESS USED FOR DEMONSTRATION COST CLAIMING**

The following cost report schedules are used to report 1115 demonstration costs incurred by MetroHealth Hospital System, a public hospital. These schedules are incorporated into the Ohio Medicaid Hospital Cost Report (JFS 02930) to ensure proper segregation of 1115 demonstration costs throughout the hospital cost report.

Schedule B: Total Facility Cost Calculation

Calculation of total facility cost to charge ratios for inpatient and outpatient services, by cost center. Total facility costs reported on the JFS 02930 are derived from Medicare Hospital Cost Report (CMS 2552-10) Worksheet C, as specified in the JFS 02930 instructions.

Schedule C: Calculation of Routine Hospital Cost

Calculation of routine hospital cost by cost center. Costs reported on this schedule are derived from CMS 2552-10 Worksheet C, Worksheet D-1, and Worksheet S-3, as specified in the JFS 02930 instructions.

Schedule D: Title XIX Cost Calculations

Calculates Medicaid-specific costs, as derived from schedules B and C of the JFS 02930.

Schedule M1: 1115 Demonstration Calculation of Routine Hospital Costs

Calculation of routine hospital cost by cost center for 1115 demonstration hospital services. This schedule does not include hospital services provided by contracted providers or other external providers. Costs reported on this schedule are derived from CMS 2552-10 worksheet C, worksheet D-1, and worksheet S-3, as specified in the JFS 02930 instructions.

Schedule M2: 1115 Demonstration Calculation of Ancillary Costs

Calculation of 1115 Demonstration hospital cost to charge ratios for inpatient and outpatient services, by cost center. The schedule corresponds to JFS 02930 schedule D, as derived from worksheet C of the CMS 2552-10.

Schedule M3: 1115 Demonstration Professional Service, Contracted Medical Service, and Administrative Cost Calculation

This schedule includes three sections: sections I and II – Professional Service Costs; section III – Contracted Medical Service Costs; and section IV – Administrative Costs

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Sections I & II – Professional Service Costs

The trial balance of MetroHealth-provided professional service costs, by patient care unit cost center. This schedule does not include professional services provided by contracted providers or other external providers. The primary groupings of patient care unit cost centers are:

- (i) EMER – Emergency Care;
- (ii) PAEC – Post Acute/Extended Care;
- (iii) PERI – Perioperative Services;
- (iv) PRIM – Primary Care;
- (v) SPEC – Specialty Care;
- (vi) SURG – Surgical Care;
- (vii) SYS – System Services; and
- (viii) WCH – Women & Children’s Care

The professional costs reported on the Ohio Medicaid Hospital Cost Report are derived from the CMS 2552-10 in conjunction with professional charges obtained from MetroHealth’s financial statements to determine an overall cost-to-charge ratio. The cost report uses cost center specific cost-to-charge ratios for settlement purposes for both interim and final reconciliation. However, for interim payment purposes an overall cost-to-charge ratio is used. The overall cost-to-charge ratios used for interim payment are calculated separately for inpatient hospital, outpatient hospital, and professional services. Note that for professional services, the cost centers are referred to as “patient care units.”

Specifically, the professional costs are derived from the CMS 2552-10 Worksheets A-8-2, and corresponding A-8 adjusting entries and A-6 reclassification entries (see Professional Waiver Services Schedule instructions). This includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Section III - Contracted Medical Services

The trial balance of contracted service and external provider expenditures, by service type. The primary groupings of contracted services are:

- (i) Federally qualified health centers;
- (ii) Durable medical equipment;
- (ii) Home health care;
- (iv) Skilled nursing facilities;
- (v) Long-term care acute care facilities;
- (vi) Medical transportation;
- (vii) Community behavioral health;
- (viii) Pharmacy;
- (viii) Hospital care; and
- (ix) Other



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The contracted medical service expenditures are equal to the sum of the actual payments made to contracted or other external providers for medical services at the contracted rates negotiated for 1115 demonstration enrollees.

Section IV - Administrative Costs

The trial balance of program administration costs. The primary groupings of program administration costs are:

- (i) Third party administrator (TPA) and pharmacy benefit manager services (PBM); and
- (ii) All other administration costs

The administrative costs are segregated and accumulated within the MetroHealth general ledger system. MetroHealth will report administrative expenses in accordance with the regulations governing reimbursement for allowable Administrative expenses as stated in 2 CFR Part 225 (OMB Circular A-87) and applicable requirements set forth in CMS 15-1 Section 2313.2(E). Only administrative costs related to administrative activities that are eligible in accordance with the CMS-approved administrative cost claiming protocol are reported on this schedule.

Schedule M4: Settlement Worksheet

This settlement worksheet computes actual reimbursement and accounts for interim payments. The 1115 demonstration costs computed from the hospital services, professional services, contracted medical services, and administrative costs schedules are transferred to the applicable settlement worksheet entry for 1115 demonstration program reconciliation.

NOTES:

(i) States making CPE-funded payments for non-hospital-based costs under section 1115(a)(2) waiver authority, must develop/identify a separate cost reporting tool and receive CMS approval for such cost reporting prior to claims for federal matching funds.

(ii) For purposes of utilizing the Ohio Medicaid Hospital Cost Report (JFS 02930) to determine Medicaid reimbursements described in the subsequent instructions, the following terms are defined:

The term “filed Medicare Cost Report” refers to the CMS 2552-10 cost report that is submitted by MetroHealth to Medicare within 150 days of the close of the hospital’s fiscal year.

The term “as filed Ohio Medicaid Hospital Cost Report” refers to the JFS 02930 cost report that is submitted by MetroHealth to the Ohio Office of Medical Assistance, and is due 6 months after the end of the cost reporting period.

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The term “interim settled Ohio Medicaid Hospital Cost Report” refers to the JFS 02930 cost report that is settled by the Ohio Office of Medical Assistance with the issuance of interim settlement.

The term “final settled Ohio Medicaid Hospital Cost Report” refers to the JFS 02930 cost report that is settled by the Ohio Office of Medical Assistance with the issuance of final settlement. The final settlement process is completed after receipt of the final-settled CMS 2552-10.

(iii) Nothing in this document shall be construed to eliminate or otherwise limit a MetroHealth’s right to pursue all administrative and judicial review available under the Medicaid program. Any revision to the finalized settlement as a result of appeals, reopening, or reconsideration shall be incorporated into the final determination.

**II. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE 1115 DEMONSTRATION HOSPITAL COSTS**

To determine MetroHealth’s allowable hospital costs (includes inpatient and outpatient hospital services provided by MetroHealth, excludes hospital services provided by non-MetroHealth hospitals) and associated 1115 demonstration reimbursements when such costs are funded by a state through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation:

**Interim 1115 Demonstration Hospital Services Payment Rate**

The purpose of an interim hospital services payment rate is to provide an interim payment that will approximate the Demonstration hospital service costs eligible for federal financial participation claimed through the CPE process. This computation of establishing interim hospital services payments funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

1. The process of determining the allowable hospital service costs eligible for Federal Financial Participation (FFP) begins with the use of the Schedules B and C from MetroHealth’s most recently filed Ohio Medicaid Hospital Cost Report for purposes of calculating interim payments. Costs reported on these schedules are derived from the Medicare Hospital Cost Report.
2. To determine the interim Medicaid payment rate, MetroHealth will use the most recently filed Ohio Medicaid Hospital Cost Report and follow the JFS 02930 instructions to arrive at the Medicaid cost-to-charge ratios for inpatient and outpatient services. For interim payments, Medicaid inpatient and outpatient cost-to-charge ratios will be used as a proxy for actual cost. The cost report uses cost center specific cost-to-charge ratios for settlement purposes for both interim and final reconciliation. However, for interim payment purposes an overall cost-to-charge ratio is used. The overall cost-to-charge ratios used for interim

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payment are calculated separately for inpatient hospital, outpatient hospital, and professional services. Charges are reported by individual cost center on the cost report.

For inpatient services the Medicaid cost-to-charge ratio will be calculated by dividing the amount shown in schedule D, column 4, line 202 by the amount on schedule D, column 3, line 202. For outpatient services the Medicaid cost-to-charge ratio will be calculated by dividing the amount shown on schedule D, column 6, line 202 by the amount shown in schedule D, column 5, line 202. Schedule D specifically calculates Medicaid Program Costs and the intent is to set the interim rate based on Medicaid costs, as a proxy for actual cost.

The state will perform the necessary review to determine the accuracy of the demonstration hospital services cost and charge data from the reported Schedules B and C on the Ohio Medicaid Hospital Cost Report. This will include reviewing the supporting documentation provided by MetroHealth, including program data from the Medicaid claims system for that period which corresponds to the filed cost report. However, because the claims system data may not include all paid claims until approximately 18 months after the fiscal year ending (FYE) of the cost report, the state will take steps to verify the filed Medicaid program data, including the use of submitted claims data. Only program data related to medical services that are eligible under the hospital services cost computation should be used in the process.

3. The hospital services Medicaid cost-to-charge ratio computed in Step number 2 above is multiplied by the claim charges for demonstration hospital services delivered by MetroHealth to calculate the interim claim payment rate. Payments are calculated separate for inpatient and outpatient using the corresponding inpatient or outpatient cost-to-charge ratio.
4. The state will make interim payments based on the hospital costs claimed by MetroHealth on a weekly basis using the interim payment methodology described in Steps number 1 through 3 above. On a weekly basis, MetroHealth will submit invoices to the state for inpatient and outpatient hospital services based on costs incurred during the designated week. Cost incurred will include covered services rendered by MetroHealth during the week. Covered services include only those services with dates of service, or dates of discharge for inpatient, on or after the demonstration effective date and within the hospital fiscal year. The amounts reported on the invoices will reflect the weekly sum of claim payments for hospital services as calculated using the applicable reimbursement methodology described in above. The weekly invoices will be reviewed by state program staff and then processed for payment by state fiscal staff.
5. Weekly claims for hospital services reported by MetroHealth should include any adjustments to prior claims to reflect increases and decreases in costs incurred resulting from adjustments. If adjustments are made to claims for which MetroHealth has already invoiced the state, MetroHealth will include those adjustments on its invoice for the week in which the adjustment was made in MetroHealth's claims system. For example, in Week 1 MetroHealth renders a service to Consumer A and includes the cost of this rendered service in its invoice for Week 1. In Week 3, MetroHealth determines that Consumer A was determined eligible for the demonstration in error and reverses in its claims system the claim for services

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rendered to Consumer A in Week 1. When MetroHealth submits its invoice for Week 3 it will include the adjustment to Consumer A's Week 1 claim as an offset to its Week 3 invoice. When MetroHealth files its Ohio Medicaid Hospital Cost Report, information reported will be based on dates of service (or dates of discharge for inpatient) that occurred during the hospital's fiscal year, and will reflect any adjustments that occurred during or after the end of the fiscal year for those dates of service.

6. Actual hospital service costs are reported on Schedules M1 and M2 on the Ohio Medicaid Hospital Cost Report after the close of the fiscal year for use in the settlement process. Schedule M1 calculates the routine costs based on the per diem and number of days. The routine costs are then carried to Schedule M2 which also calculates the ancillary costs. The cost columns are then summed to arrive at total inpatient or outpatient costs.

All costs must be properly documented by MetroHealth, and are subject to review by the state and CMS.

**Interim 1115 Demonstration Hospital Services Reconciliation of Interim Hospital Payment Rates**

MetroHealth's interim demonstration payments will be reconciled to its filed Ohio Medicaid Hospital Cost Report (JFS 02930) for the hospital fiscal year in which interim payments were made. If, at the end of the interim reconciliation process, it is determined that MetroHealth received an overpayment, the overpayment will be properly credited to the federal government. If, at the end of the interim reconciliation process, it is determined that an additional amount is due to MetroHealth, the additional amount due will be properly claimed to the federal government.

After the end of the fiscal year, MetroHealth must file its Ohio Medicaid Hospital Cost Report within 6 months of the close of its fiscal year. MetroHealth operates on a calendar year fiscal year, so its cost report submission deadline will be June 30th of the following calendar year. The state will then perform interim settlement by December 31st of the calendar year in which the cost report is filed by MetroHealth. These timeframes are subject to any cost report extensions granted by Medicare or by the state, as necessary, to ensure proper reporting. Extensions granted by the state that are not the result of an extension granted by Medicare must not exceed 30 days. The state must issue the results of the interim settlement within 180 days of receipt of MetroHealth's Medicaid Hospital Cost Report. Any overpayment amounts due from MetroHealth must be collected within 45 days from the issuance of the interim settlement results. The federal portion of any overpayment collected by the state must be returned to CMS on the next CMS-64. If there are no budget neutrality restrictions, any underpayment amounts due to MetroHealth will be paid within 45 days from the issuance of an adjudication order. If there are no budget neutrality restrictions, the federal portion of any underpayment made by the state will be claimed to CMS on the next CMS-64.

MetroHealth will complete Schedules M1 and M2 of the JFS 02930 following the close of the fiscal year to report actual Demonstration hospital costs. Inpatient and outpatient costs will be

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segregated for reporting and settlement. Actual demonstration hospital costs reported on Schedules M1 and M2 of the JFS 02930 will be compared to the sum of interim hospital payments for the time period corresponding to the filed cost report. If actual hospital costs are greater than the interim hospital payments received, then MetroHealth will receive additional payment equal to the difference between actual hospital costs and the sum of the interim payments. If actual hospital costs are less than the interim hospital payments received, then MetroHealth will owe an amount due equal to the difference between actual hospital costs and the sum of the interim payments. Actual settlement amounts due will be converted to the applicable federal financial participation rate in effect during the hospital's fiscal year, which will include blending of quarterly federal medical assistance percentages where necessary.

As explained in the Interim Medicaid Hospital Payment Rate section of this document, data generated from the demonstration claims system will not be complete, and steps to verify the data will be taken by the state including the use of submitted demonstration claims. Only demonstration program data related to hospital services that are eligible under the hospital cost computation should be used in this process. Adjustments made to the claims data mentioned above may address outstanding demonstration claims for which MetroHealth has not received payment. The state will take steps to ensure that payments associated with the pending claims, when paid, for demonstration costs included in the current hospital fiscal year cost report are properly accounted.

**Final 1115 Demonstration Hospital Services Payment Reconciliation**

MetroHealth's interim hospital payments and interim settlement adjustments in a fiscal year will also be subsequently reconciled to its JFS 02930 cost report for that same fiscal year as finalized by the state for purposes of Medicaid reimbursement. If, at the end of the final reconciliation process, it is determined that MetroHealth received an overpayment, the overpayment must be properly credited to the federal government. If, at the end of the final reconciliation process it is determined that an additional amount is due to MetroHealth, that additional amount will be paid to MetroHealth and properly claimed to the federal government.

Final settlement must occur within 180 days of receipt of the final Medicare cost report for MetroHealth's Medicaid Hospital Cost report. Final reconciliation is dependent upon receipt of the final Medicare cost report. Any overpayment amounts are due from MetroHealth within 45 days from the issuance of an adjudication order. The federal portion of any overpayment must be collected by the state within one year and will be returned to CMS on the next CMS-64. Any underpayment amounts due to MetroHealth will be paid within 45 days from the issuance of an adjudication order. The federal portion of any underpayment made by the state will be claimed to CMS on the next CMS-64.

MetroHealth will complete Schedules M1 and M2 of the JFS 02930 on the final filed cost report to report actual Demonstration hospital costs. Inpatient and outpatient costs will be segregated for reporting and settlement. Actual Demonstration hospital costs reported on schedules M1 and M2 of the JFS 02930 will be compared to the sum of interim hospital payments and settlement adjustments for the time period corresponding to the filed cost report. If actual hospital costs are

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greater than the interim hospital payments and settlements received, then MetroHealth will receive additional payment equal to the difference between actual hospital costs and the sum of the interim payments. If actual hospital costs are less than the interim hospital payments and settlements received, then MetroHealth will owe an amount due equal to the difference between actual hospital costs and the sum of the interim payments. Actual settlement amounts due will be converted to the applicable federal financial participation rate in effect during the hospital fiscal year, which will include blending of quarterly federal medical assistance percentages where necessary.

At the time of final reconciliation, data generated from the demonstration claims system will be considered complete, and steps to verify the data will be taken by the state including the use of submitted Demonstration claims. All final reconciliations must use final paid claims rather than submitted claims. Only demonstration program data related to hospital services that are eligible under the hospital cost computation should be used in this process.

**III. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE 1115 DEMONSTRATION PROFESSIONAL SERVICE, AND CONTRACTED MEDICAL SERVICE COSTS**

To determine MetroHealth's allowable professional services and contracted medical service reimbursements when such costs are funded by a state through the certified public expenditure (CPE) process, the following steps must be taken to ensure federal financial participation:

**Interim 1115 Demonstration Professional Services Payment Rate**

The purpose of an interim professional services payment rate is to provide an interim payment that will approximate the demonstration professional service costs eligible for federal financial participation claimed through the CPE process. This computation of establishing interim professional services payments funded by CPEs must be performed on an annual basis, and in a manner consistent with the instructions below.

1. The process of determining the allowable Medicaid professional service costs eligible for federal financial participation (FFP) begins with the use of the sections I and II of schedule M3 from MetroHealth's most recently filed Ohio Medicaid Hospital Cost Report for purposes of calculating interim reimbursement. For the first fiscal year of operation of the 1115 Waiver Demonstration by MetroHealth, if an Ohio Medicaid Hospital Cost Report has already been submitted prior to the inclusion of the schedule M3; then MetroHealth must file Schedule M3 separately prior to demonstration program implementation using the Medicare Cost Report and hospital financial statements corresponding to the fiscal year that aligns with the most recent filed Ohio Medicaid Hospital Cost Report as of the effective date of the 1115 demonstration.
2. To determine the interim professional service payment rate, MetroHealth will use the most recently filed Sections I and II of Schedule M3 from the Ohio Medicaid Hospital Cost

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Report, follow the professional services cost calculation instructions to arrive at the professional service cost-to-charge ratio.

Professional services are found within small group of general ledger accounts on MetroHealth's financial statements. Professional services costs are reported as general service costs on the Medicare Cost Report, and cannot be differentiated between inpatient and outpatient, while professional service charges are cost center specific. Therefore, in order to complete section I and II of schedule M3, MetroHealth will roll up professional costs and charges at the patient care unit level. A cost-to-charge ratio is then calculated for each patient care unit and the aggregate cost-to-charge ratio is used to calculate interim payments.

Sections I and II of schedule M3 begin with physician costs by patient care unit from worksheet A-8-2 of the Medicare Cost Report. Reasonable Compensation Equivalent disallowances from Worksheet C of the Medicare Cost Report are then removed from the physician costs. Other professional service costs (CRNAs, Nurse Practitioner, Physician Assistant) as found in Worksheet A-8 of the Medicare Cost Report are added, as well as professional billing expenses that remain on worksheet A, line 98.05, column 7, that is expenses after reclassification F as reported on worksheet A-6. Total professional costs are then divided by total professional charges to calculate patient care unit cost-to-charge ratios, as well as the aggregate cost-to-charge ratio for all professional services.

The state will perform the necessary review to determine the accuracy of the demonstration professional services cost and charge data from the reported sections I and II of schedule M3 on the Ohio Medicaid Hospital Cost Report. The review includes verifying amounts were properly carried over from the Medicare cost report, comparing the Medicaid (or Demonstration) information reported to the relevant information in the Medicaid (or Demonstration) claims system, and verifying amounts entered match the corresponding amounts on any other source documentation. Additionally, this will include reviewing the supporting documentation provided by MetroHealth, including program data from the Demonstration claims system for that period which corresponds to the filed cost report once the Demonstration has been implemented. However, because the claims system data may not include all paid claims until 18 months after the fiscal year ending (FYE) of the cost report, the state will take steps to verify the filed Demonstration program data, including the use of submitted claims data. Only Demonstration program data related to medical services that are eligible under the professional services cost computation should be used in the process.

3. The professional services cost-to-charge ratio computed in step number 2 above is multiplied by the claim charges for professional services delivered by MetroHealth to calculate the interim claim payment rate.
4. The state will make interim payments based on the professional costs claimed by MetroHealth on a weekly basis using the interim payment methodology described in step number 1 through 3 above. On a weekly basis, MetroHealth will submit invoices to the state for professional services based on costs incurred during the designated week. Cost incurred will include covered services rendered by MetroHealth during the week. Covered services

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include only those services with dates of service on or after the demonstration effective date and within the hospital fiscal year. The amounts reported on the invoices will reflect the weekly sum of claim payments for medical services as calculated using the applicable reimbursement methodology described above. The weekly invoices will be reviewed by state program staff, and then processed for payment by state fiscal staff.

5. Weekly claims for professional services reported by MetroHealth should include any adjustments to prior claims to reflect increases and decreases in costs incurred resulting from adjustments. If adjustments are made to claims for which MetroHealth has already invoiced the state, MetroHealth will include those adjustments on its invoice for the week in which the adjustment was made in MetroHealth's claims system. For example, in Week 1 MetroHealth renders a service to Consumer A and includes the cost of this rendered service in its invoice for Week 1. In Week 3, MetroHealth determines that Consumer A was determined eligible for the demonstration in error and reverses in its claims system the claim for services rendered to Consumer A in Week 1. When MetroHealth submits its invoice for Week 3 it will include the adjustment to Consumer A's Week 1 claim as an offset to its Week 3 invoice. When MetroHealth files its Ohio Medicaid Hospital Cost Report, information reported will be based on dates of service (or dates of discharge for inpatient) that occurred during the hospital's fiscal year and will reflect any adjustments that occurred during or after the end of the fiscal year for those dates of service.
6. Actual professional service costs will be reported on Schedule M3 of the JFS 02930 after the close of the fiscal year for settlement purposes.

All costs must be properly documented by MetroHealth, and are subject to review by the state and CMS.

**Interim 1115 Demonstration Contracted Medical Services Payment Rate**

The purpose of an interim contracted medical services payment rate is to provide an interim payment that will approximate the contracted medical service costs eligible for federal financial participation claimed through the CPE process.

1. The process of determining the allowable contracted medical service costs eligible for federal financial participation (FFP) begins with MetroHealth's weekly claims for contracted medical service costs for the purpose of determining interim payments. The contracted service costs are equal to the sum of the actual payments made to contracted or other external providers at the contracted rates negotiated for 1115 demonstration enrollees. Contracted rates shall not be greater than the Ohio Medicaid fee schedules for the same services. For demonstration network pharmacies, MetroHealth's cost for its 340B pharmacies includes the drug and associated administrative costs for filling the covered prescriptions.

The state will perform those tests necessary to determine the reasonableness of the demonstration contracted medical services cost data. This will include reviewing any supporting documentation provided by MetroHealth, including program data from the



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demonstration claims system for that period which corresponds to the filed cost report once the demonstration has been implemented. However, because the claims system data may not include all paid claims until 18 months after the fiscal year ending (FYE) of the cost report, the state will take steps to verify the filed demonstration program data, including the use of submitted claims data. Only demonstration program data related to medical services that are eligible under contracted medical services cost computation should be used in the process.

2. The state will make interim payments based on the contracted medical service costs claimed by MetroHealth on a weekly basis using the costs described in Step number 1 above. On a weekly basis, MetroHealth will submit invoices to the state for contracted medical services based on costs incurred during the designated week. Cost incurred will include claims paid by the Demonstration during the week for covered services rendered by external providers (i.e. providers other than MetroHealth, such as claims from other hospital emergency departments or contracted services). Covered services include only those services with dates of service, or dates of discharge for inpatient, on or after the demonstration effective date and within the hospital fiscal year. The amounts reported on the invoices will reflect the weekly sum of claim payments for medical services as calculated using the applicable reimbursement methodology described above. The weekly invoices will be reviewed by state program staff, and then processed for payment by state fiscal staff.
3. Weekly claims for contracted medical services reported by MetroHealth should include any adjustments to prior claims to reflect increases and decreases in costs incurred resulting from adjustments. If adjustments are made to claims for which MetroHealth has already invoiced the state, MetroHealth will include those adjustments on its invoice for the week in which the adjustment was made in MetroHealth's claims system. For example, in Week 1 MetroHealth renders a service to Consumer A and includes the cost of this rendered service in its invoice for Week 1. In Week 3, MetroHealth determines that Consumer A was determined eligible for the Demonstration in error and reverses in its claims system the claim for services rendered to Consumer A in Week 1. When MetroHealth submits its invoice for Week 3 it will include the adjustment to Consumer A's Week 1 claim as an offset to its Week 3 invoice. When MetroHealth files its Ohio Medicaid Hospital Cost Report, information reported will be based on dates of service (or dates of discharge for inpatient) that occurred during the hospital's fiscal year, and will reflect any adjustments that occurred during or after the end of the fiscal year for those dates of service.
4. Contracted medical services costs are reported in section III of schedule M3 on the Ohio Medicaid Hospital Cost Report after the close of the fiscal year for use in the settlement process.

All costs must be properly documented by MetroHealth, and are subject to review by the state and CMS.

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**Interim Settlement of 1115 Demonstration Professional Services and Contracted Medical Service Payments**

MetroHealth's interim Demonstration professional services and contracted medical services payments will be reconciled to its filed Ohio Medicaid Hospital Cost Report (JFS 02930) for the fiscal year in which payments were made. If, at the end of the interim reconciliation process, it is determined that MetroHealth received an overpayment, the overpayment must be properly credited to the federal government. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were understated and there are no budget neutrality restrictions, the underpayment will be properly claimed to the federal government.

After the end of the fiscal year, MetroHealth will file its Ohio Medicaid Hospital Cost Report within 6 months of the close of its fiscal year. MetroHealth operates on a calendar year fiscal year, so its cost report submission deadline will be June 30th of the following calendar year. The state will then perform interim settlement by December 31st of the calendar year in which the cost report is filed by MetroHealth. These timeframes are subject to any cost report extensions granted by Medicare or by the state as necessary to ensure proper reporting. Extensions granted by the state that are not the result of an extension granted by Medicare shall not exceed 30 days. Any overpayment amounts due from MetroHealth within 45 days from the issuance of an adjudication order. The federal portion of any overpayment must be collected by the state within 180 days of submission of the final cost reports, and must be returned to CMS on the next CMS-64. Any underpayment amounts due to MetroHealth will be paid within 45 days from the issuance of an adjudication order. The federal portion of any underpayment made by the state will be claimed to CMS on the next CMS-64.

MetroHealth will complete Schedule M3 of the JFS 02930 following the close of the fiscal year to report actual Demonstration professional services and contracted medical service costs. This includes professional costs reported on sections I and II and contracted medical services costs reported on section III. Interim reconciliation will occur using the following methodology:

**Professional Costs**

Actual Demonstration professional costs reported on JFS 02930 Schedule M3, sections I and II, will be compared to the sum of interim professional payments for the time period corresponding to the filed cost report. If actual professional costs are greater than the interim professional payments received, then MetroHealth will receive additional payment equal to the difference between actual professional costs and the sum of the interim payments. If actual professional costs are less than the interim professional payments received, then MetroHealth will owe an amount due equal to the difference between actual professional costs and the sum of the interim payments. Settlement payments will be made in accordance with the timeframes described above.

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Contracted Medical Service Costs

Actual 1115 Demonstration contracted medical service costs reported in section III of schedule M3 of the JFS 02930 will be compared to the sum of interim contracted medical services payments for the time period corresponding to the filed cost report. If actual contracted medical service costs are greater than the interim contracted medical service payments received, then MetroHealth will receive additional payment equal to the difference between actual contracted medical service costs and the sum of the interim payments. If actual contracted medical service costs are less than the interim contracted medical service payments received, then MetroHealth will owe an amount due equal to the difference between actual contracted medical service costs and the sum of the interim payments. Settlement payments will be made in accordance with the timeframes described above.

Actual settlement amounts due will be converted to the applicable federal financial participation rate in effect during the hospital fiscal year, which will include blending of quarterly federal medical assistance percentages where necessary.

As explained in the interim payment rate sections of this document, data generated from the demonstration claims system will not be complete, and steps to verify the data will be taken by the state including the use of submitted demonstration claims. Only demonstration program data related to professional service and contracted medical service costs are eligible under this cost computation which should be used in this process.

Adjustments made to the claims data mentioned above may address outstanding demonstration claims for which MetroHealth has not received payment. The state will take steps to ensure that payments associated with the pending claims, when paid, for demonstration costs included in the current hospital fiscal year cost report are properly accounted.

**Final Settlement of 1115 Demonstration Professional Service and Contracted Medical Service Interim Payments**

MetroHealth's interim demonstration professional service and contracted medical service payments will be reconciled to its final filed Ohio Medicaid Hospital Cost Report (JFS 02930) for the fiscal year in which interim payments were made. If, at the end of the final reconciliation process, it is determined that MetroHealth received an overpayment, the overpayment must be properly credited to the federal government. If, at the end of the interim reconciliation process, it is determined that expenditures were understated and there are no budget neutrality restrictions, the additional amount due will be paid to MetroHealth and properly claimed to the federal government.

Final settlement must occur within 180 days of receipt of the final Medicare cost report for MetroHealth's Medicaid Hospital Cost Report. Final reconciliation is dependent upon receipt of the final Medicare cost report. Any overpayment amounts are due from MetroHealth within 45 days from the issuance of an adjudication order. The federal portion of any overpayment must be collected by the state within 180 days of submission of the final cost report and must be

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returned to CMS on the next CMS-64. Any underpayment amounts due to MetroHealth will be paid within 45 days from the issuance of an adjudication order. The federal portion of any underpayment made by the state will be claimed to CMS on the next CMS-64.

MetroHealth will complete schedule M3 of the JFS 02930 following the close of the fiscal year to report actual Demonstration professional service and contracted medical service costs. This includes professional costs reported on sections I and II, and contracted medical services costs reported on section III. Final reconciliation will occur using the following methodology:

Professional Costs

Actual demonstration professional costs reported on JFS 02930 schedule M3, sections I and II, will be compared to the sum of interim professional payments, including interim settlement adjustments, for the time period corresponding to the filed cost report. If actual professional costs are greater than the interim professional payments received, then MetroHealth will receive additional payment equal to the difference between actual professional costs and the sum of the interim payments including interim settlement adjustments. If actual professional costs are less than the interim professional payments received, then MetroHealth will owe an amount due equal to the difference between actual professional costs and the sum of the interim payments including interim settlement adjustments. Settlement payments will be made in accordance with the timeframes described above.

Contracted Medical Service Costs

Actual 1115 demonstration contracted medical service costs reported in section III of schedule M3 of the JFS 02930 will be compared to the sum of interim contracted medical services payments and interim settlement adjustments for the time period corresponding to the filed cost report. If actual contracted medical service costs are greater than the interim contracted medical service payments received, then MetroHealth will receive additional payment equal to the difference between actual contracted medical service costs and the sum of the interim payments and interim settlement adjustments. If actual contracted medical service costs are less than the interim contracted medical service payments received, then MetroHealth will owe an amount due equal to the difference between actual contracted medical service costs and the sum of the interim payments and interim settlement adjustments. Settlement payments will be made in accordance with the timeframes described above.

Actual settlement amounts due will be converted to the applicable federal financial participation rate in effect during the hospital fiscal year, which will include blending of quarterly federal medical assistance percentages where necessary.

At the time of final reconciliation, data generated from the demonstration claims system will be considered complete, and steps to verify the data will be taken by the state including the use of submitted demonstration claims. The state must use final paid claims for final reconciliation, rather than submitted claims. Only demonstration program data related to services that are

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eligible under the cost computation for professional services and contracted medical services should be used in this process.

**IV. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE 1115 DEMONSTRATION ADMINISTRATIVE COSTS**

**Monthly 1115 Demonstration Administrative Cost Reimbursement**

The purpose of monthly administrative cost reimbursement is to provide monthly payments for administrative eligible for Federal financial participation (at the administration rate of 50 percent) claimed through the CPE process.

1. The process of determining the allowable administrative costs eligible for federal financial participation (FFP) begins with MetroHealth's monthly claim for administrative costs for the purpose of determining monthly payments. The administrative costs are equal to the sum of the actual costs for administrative activities. Administrative costs for the 1115 demonstration are segregated and accumulated within the MetroHealth general ledger system MetroHealth will report administrative expenses in accordance with the regulations governing reimbursement for allowable Administrative expenses as stated in 2 CFR Part 225 (OMB Circular A-87) and applicable requirements set forth in CMS 15-1 section 2313.2(E). The state will perform those tests necessary to determine the reasonableness of the demonstration administrative costs. This will include reviewing any supporting documentation provided by MetroHealth, including MetroHealth's general ledger for that period which corresponds to the administrative claim. Only administrative data related to administrative activities that are eligible under the administrative cost computation should be used in the process.
2. The state will make monthly payments based on the administrative costs claimed by MetroHealth on a monthly basis using the costs described in Step number 1 above. On monthly basis, MetroHealth will submit invoices for administrative costs incurred during the designated month. Administrative costs incurred will include costs for allowable activities performed by MetroHealth staff directly during the month, as well as those payments made in the designated month to contracted entities performing allowable administrative activities.
3. Monthly claims for administrative costs reported by MetroHealth should include any adjustments to prior claims to reflect increases and decreases in actual costs incurred resulting from adjustments.
4. Administrative costs are reported in section IV of schedule M3 on the Ohio Medicaid Hospital Cost Report after the close of the fiscal year for use in the settlement process.

All costs must be properly documented by MetroHealth, and are subject to review by the state and CMS.

The state will report the administrative claims on the CMS 64 on a quarterly basis.

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I. Preface

As part of the total amount payable under the demonstration authority granted under section 1115(a)(2) of the Social Security Act (the Act) by the Centers for Medicare & Medicaid Services (CMS) to the Ohio/MetroHealth Care Plus section 1115 demonstration (federal financial participation (FFP) as authorized by 42 Code of Federal Regulations (CFR) 433.15) is available to MetroHealth at the 50 percent rate for administrative costs required for "proper and efficient" administration of the demonstration subject to the limitations outlined below.

Ohio's MetroHealth Care Plus demonstration will be administered in collaboration with the MetroHealth System, a public hospital. The state will not be expanding its administrative capacities to accommodate this demonstration. Therefore, all increases in administrative activities are being assumed by MetroHealth, as reflected in this Administrative Cost Claiming Protocol.

Examples of administrative activities that will be performed by MetroHealth include:

- Targeted marketing and public outreach to provide information about program services and encourage eligible low-income persons to apply;
- Eligibility screening and enrollment processes and systems to identify and facilitate the enrollment of eligible low-income, uninsured persons into demonstration program coverage;
- Development and maintenance of data collection and quality monitoring systems that facilitate reporting and analyses;
- Member education, such as production and distribution of benefits materials, and community and on-site information sessions to maximize use of the program;
- Data collection and analyses of reports, studies, or surveys required by CMS or Ohio Office of Medical Assistance;
- Developing, monitoring, and administering contracts or other arrangements with private and/or other public entities for delivery of services; and
- Operations of the Program administrative functions, e.g. salaries and benefits of employees assigned to operate and support the demonstration program functions, and Third Party Administrator (TPA)/Pharmacy Benefit Manager (PBM) administration fees.

The following guidance and protocols are based on and in response to information submitted in writing or otherwise communicated to CMS and are provided to inform the state and assist the state in its efforts to comply with the rules and protocols regarding claiming for FFP for administrative expenditures incurred by the state and/or its contractors under this demonstration.

A. General Requirements

The state must comply with all federal statute, regulations and guidance for all claims for FFP.

In order for the costs of administrative activities to be claimed as demonstration administrative expenditures at the 50 percent FFP rate, the following requirements must be met:

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- Costs must be “necessary for the proper and efficient administration” of the demonstration (Section 1903(a)(7) of the Social Security Act, referring to the Medicaid State Plan).
- If applicable, costs must be allocated in accordance with the relative benefits received by all programs, not just the 1115 demonstration.
- Claims for costs must not duplicate costs that have been, or should have been, paid through another source.
- State or local governmental agency costs must be supported by an allocation methodology under the applicable approved public assistance Cost Allocation Plan (42 CFR 433.34).
- Costs must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a provider facility or otherwise include costs of a direct service to beneficiaries (these should be claimed as service costs, not plan administration).
- Costs must not duplicate activities that are already being offered or should be provided by other entities, or through other programs.
- Costs must be supported by adequate source documentation.
- Costs must not be federally-funded or used for any other federal matching purposes.

B. Interagency Agreements

Because only the State Medicaid agency may submit a claim to CMS to receive FFP for allowable and properly allocated demonstration costs, every participating entity that is performing administrative activities on behalf of the demonstration program must be covered, either directly or indirectly, through an interagency agreement. This agreement must be in effect before the Medicaid agency may claim federal matching funds for any administrative activities conducted by MetroHealth as detailed in the agreement with the Medicaid agency. For purposes of Ohio’s MetroHealth Care Plus section 1115 demonstration, the administrative activities performed by MetroHealth on behalf of the State Medicaid agency will be covered through a subgrant agreement between the State Medicaid agency and MetroHealth. The state Medicaid agency will be entering into a subgrant agreement with MetroHealth. The state will forward a copy of the subgrant agreement to CMS. The subgrant agreement will indicate that MetroHealth will be assuming all administrative activities associated with the demonstration. The state Medicaid agency is not hiring any additional staff for these administrative requirements. As such, the administrative activities that would otherwise have been the responsibility of the state Medicaid agency will be conducted by MetroHealth and subject to administrative claiming.

In order to provide a basis for FFP to be claimed, the agreement will describe and define the relationships between the State Medicaid agency and MetroHealth and will document the scope of the activities being performed by MetroHealth. The subgrant agreement will include:

- Mutual objectives of the agreement;
- Responsibilities of all the parties to the agreement;

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- Activities or services each party to the agreement offers and under what circumstances;
- Cooperative and collaborative relationships at the state and local levels;
- Specific administrative claiming activity codes which have been approved by CMS, by reference or inclusion;
- Specific methodology which has been approved by CMS for computation of the administrative claim, by reference or inclusion;
- Methods for reimbursement, exchange of reports and documentation, and liaison between the parties, including designation of state and local liaison staff.

The subgrant agreement will address the demonstration administrative claiming process, identify the services the state Medicaid agency will provide for the local entity, including any related reimbursement and funding mechanisms, and define oversight and monitoring activities and the responsibilities of all parties. All participation requirements from the state Medicaid agency are mandatory to ensure a valid process and will be detailed in the agreement. Maintenance of records, participation in audits, designation of local project coordinators, training timetables and criteria, and submission of fiscal information are all important elements of the subgrant agreement. Also, the specific methodologies, which may include a standardized claim form, the mechanism for filing the claim, and the approved allocation methodology that may include use of a time study by the local entity, will be elements of the agreement.

Many interagency agreements require the governmental agency that performs the administrative activities to provide the required state match for Demonstration administrative claiming. As always, the non-federal share of the Demonstration payments must be derived from permissible sources (e.g., appropriations, intergovernmental transfers, certified public expenditures, provider taxes) and must comply with Federal regulations and policy. For purposes of this demonstration, the non-federal share of payments for the administrative activities performed by MetroHealth in accordance with the agreement will be provided by MetroHealth using Certified Public Expenditures (CPEs). MetroHealth will be required to ensure that the non-federal share of payments for administrative activities are derived from permissible sources in accordance with Federal regulations and policy, and to report expenditures in accordance with the CMS-approved cost claiming protocol.

C. Identification, Documentation and Allocation of Costs

All administrative costs (direct and indirect) are normally charged to federal grant awards such as Medicaid through the State's public assistance cost allocation plan (CAP). Federal regulations (42 CFR 433.34) require that under the Medicaid state plan, the single state agency have an approved public assistance CAP on file with the Division of Cost Allocation in the U.S. Department of Health and Human Services that meets certain regulatory requirements, which are specified at Subpart E of 45 CFR part 95 and referenced in OMB Circular A-87. There are certain items that must be in the public assistance CAP which a state Medicaid agency must submit before providing FFP for administrative claiming. The public assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues pertinent to the allocation of costs and submission of claims by the participating entities.



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Documentation for administrative activities must clearly demonstrate that the activities directly support the administration of the demonstration program. In accordance with the statute, the regulations, and the Medicaid state plan, the state is required to maintain/retain adequate source documentation to support demonstration payments. The basis for this requirement can be found in statute and regulations. See section 1902(a)(4) of the Act and 42 CFR 431.17; see also 45 CFR 92.20(b) and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 92.42 and 42 CFR 433.32(b and c) (retention period for records). The records must be made available for review by state and federal staff upon request during normal working hours (section 1902(a) (4) of the Act, implemented at 42 CFR 431.17).

When states submit claims for FFP for demonstration administration, only costs directly related to demonstration administration are allowable and these costs must be allocated according to accepted cost principles. Since most administrative activities are provided both to demonstration and non-demonstration eligible individuals, the costs applicable to these activities must be allocated to both groups.

## II. Principles of Administrative Cost Claiming

### A. General

MetroHealth employees may perform administrative activities that directly support the operation of the Demonstration program. Some or all of the costs of these administrative activities and certain purchased services may be reimbursable under the demonstration; however, an appropriate claiming mechanism must be used. The time study, 100 percent timekeeping, and monthly personnel reporting are mechanisms utilized to identify and categorize administrative activities. The method and documentation that MetroHealth will use is described below. Section II.C.8. describes the activity codes. If additional activity codes become needed, those would also be in accordance with these principles for claiming purposes and approved by CMS.

### B. Time and Effort Reporting

#### 1. Documentation

The methodology and instructions, as well as the cost allocation requirements issued by the state Medicaid agency, must stipulate the documentation MetroHealth must maintain to support the claims submitted to the state. The documentation for administrative activities must clearly demonstrate that the activities/services directly support the administration of the Medicaid program. In accordance with the statute, the regulations, and the Medicaid state plan, the state is required to maintain/retain adequate source documentation to support the Medicaid payments for administrative claiming. The basis for this requirement can be found in statute and regulations. See section 1902(a)(4) of the Act and 42 CFR 431.17; see also 45 CFR 74.53 and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 74.20 and 42 CFR 433.32(b and c) (retention period for records). The administrative claiming records must be made available for review by state and federal staff upon request during normal working hours (section 1902(a)(4) of the Act, implemented at 42 CFR 431.17). It is the state's

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responsibility to ensure that the applicable policies are applied uniformly throughout the state, and that claims submitted to CMS are in conformance with such requirements.

Documentation maintained in support of administrative claims must be sufficiently detailed to permit CMS to determine whether the activities are necessary for the proper and efficient administration of the state plan. Simply checking a box on a time study form does not facilitate independent validation. The burden of proof and validation of time study sample results remains the responsibility of the state. Additional guidance regarding documentation for compensation of salary and wages is found in OMB Circular A-87, Attachment B, section 11.h.(5):

Personnel activity reports or equivalent documentation must meet the following standards:

- They must reflect an after-the-fact distribution [i.e., distribution following completion of the activity] of the actual activity of each employee;
- They must account for the total activity for which each employee is compensated;
- They must be prepared at least quarterly and must coincide with at least one week; and
- They must be signed by the employee as being a true statement of activities and the employee/office will retain documentation to support the report.

Note, the requirement to document costs monthly does not necessarily mean that if a time study mechanism is selected, that it must be conducted monthly. OMB Circular A-87 makes a distinction between documentation of costs and the methods/mechanisms for allocating such costs. While costs must be documented at least on a monthly basis, time studies, which are conducted for purposes of allocating costs, can occur on a quarterly basis or some other statistically valid time frame. ASMB C-10, the U.S. Department of Health and Human Services' implementation guide for OMB Circular A-87, provides further guidance on the requirements and circumstances dictating the frequency of time and effort reporting.

Other principles related to documentation and documentation requirements that apply in addition to the above requirements are:

- The documentation related to salaries and wages, including personnel activity reports, is required;
- Accounting records should be supported by source documentation such as canceled checks, paid bills, payrolls, contract and subgrant award documents;
- Costs must be verified as being incurred in a particular federal program;
- Undocumented personnel costs are not allowed; and
- Adequate documentation for labor costs is required.

Position descriptions can be useful as supporting documentation for staff participating in time studies. However, position or job descriptions are often generic and may indicate that "other administrative duties" are included, without providing a definition for those administrative functions. In many cases, these "other administrative duties" may be understood to include the performance of Medicaid related activities and the completion of time studies. In that regard, it may be helpful, though it is not required, to include in the position descriptions for those

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participating in administrative claiming further explanation or documentation of the Medicaid related activities performed, particularly if the position descriptions do not reflect any aspect of the performance of such activities.

Other administrative costs will be provided by non-MetroHealth employees through a purchase arrangement. For the purposes of administrative claiming, these costs will be documented with invoices. Information provided on or with the invoice will provide sufficient detail to describe the service and the relationship to the demonstration, and, in particular, that the sole benefit of the purchased service was for the demonstration.

## 2. Sampling/Time Studies or Other Mechanisms for Effort Reporting

OMB Circular A-87 states that, with regard to sampling:

“Substitute systems for allocating salaries and wages to federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort.” Any such system must be approved by the funding agency. These sampling systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort or outcomes. For time studies, all activities need to be sampled even if they are not strictly related to Medicaid.

Relevant sections of OMB Circular A-87 include the following:

- Attachment A, Section A.1. Each awarding grant bears its fair share of costs; C, Basic Guidelines, 1.h: Not included as match for another federal program. 1.J: Be adequately documented. 3.c: Costs cannot be shifted from one grant to another to avoid restrictions.
- Attachment B, selected items of Cost, 11. Compensation for personnel services, h (1-4): standards for payroll documentation. (6) Substitute Systems are: subject to approval; include random moment sampling or other quantifiable measures; (a) must meet acceptable statistical sampling standards including: (I) include all salaries of employees to be allocated; (ii) the entire time period involved must be covered; (c) less than full compliance with statistical sampling standards may be accepted by the agency if it concludes that the proposal will result in lower costs to federal awards than the compliant system.

Major time study issues include the following: development and approval of the activity codes to be used, the participants to be sampled, the sampling plan, statistical validity (95 percent or higher confidence level for a 5 percent error limit), documentation, training for staff in the sample universe, and monitoring.

- Universe of Staff/Personnel Costs for Administrative Claiming

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A list of the job titles of MetroHealth staff that participate in administrative activities specific to the demonstration, and would be included for the purposes of administrative claiming includes the following positions:

- Executive Director-Managed Care Programs
- Managed Care Medical Director
- Manager Patient Population Analytics (a.k.a. Analyst)
- Medicaid Waiver Program Business Analyst
- Eligibility Researcher
- Care Coordinators

The time dedicated to the demonstration is strictly for administrative responsibilities. The positions can be grouped into two categories, administrative case management, provided by the Care Coordinators, and other administrative support/leadership, provided by the remaining positions specified. Each of the roles and the administrative responsibilities for the demonstration is described in section 6 “Allocable Share of Costs.

- Implementation

MetroHealth will utilize two methods to account for the administrative costs: (1) for the Care Coordinators; and (2) for the other administrative support/leadership staff. All staff subject to administrative claiming will keep a record of hours worked on a daily basis. The time record will be maintained in Kronos, an electronic time documentation system housed at MetroHealth. Daily time worked will be tracked, approved, and maintained for reporting and auditing purposes. The daily time record shall be reviewed and approved every 2 weeks by both the individual employee and the employee’s supervisor.

The administrative staff who are not Care Coordinators will enter the appropriate codes into Kronos, to distinguish the time spent on different allowable and unallowable activities. Please see the description of the code set below.

The Care Coordinators are not providing direct care to beneficiaries. Their work will be less diverse and variable than the other administrative support/leadership staff. For this reason MetroHealth will use a periodic certification of activity by the Care Coordinators, rather than code specific documentation. The Medicaid Eligibility Rate (MER) for the Care Coordinators will be determined by the percentage of the total caseload supported by the designated Care Coordinators that is Medicaid Demonstration versus non Medicaid demonstration. The MER will be established using caseload information from the preceding quarter. Additional requirements for documentation, and job descriptions etc. referenced elsewhere in this protocol, and will be maintained.

- Training for Staff Participating in Administrative Claiming

All staff who will be subject to administrative claiming will be adequately trained before the documentation and claiming begins. Training should cover all aspects of the process. Staff

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should be clear on how to complete the form, how to report activities under the appropriate codes, the difference between demonstration-related and other activities, and where to obtain technical assistance if there are questions. Professional staff must understand the distinctions between the performance of administrative activities and direct medical services.

There will be a mechanism in place to assess how often training is necessary and to revise the training schedule, if appropriate. To ensure consistent application, all training documentation, including the schedule of training on time-keeping and the approved activity codes, should be maintained and available for audit purposes. The training schedule should show the training required of the designated staff, designated staff, and frequency of training. The frequency of training should take into account turnover at the local level.

### Monitoring Process

The state Medicaid agency must monitor the compliance of MetroHealth with the requirements of the administrative claiming methodology. The state Medicaid agency will conduct a desk review of the protocol and the results four times throughout the demonstration period, and notify MetroHealth if any corrections are needed.

## C. Operational Principles

### 1. Proper and Efficient Administration

According to the Medicaid statute at section 1903(a)(7) of the Act and the implementing regulations at 42 CFR 430.1 and 42 CFR 431.15, for the cost of any activities to be allowable and reimbursable under the Demonstration, the activities must be “found necessary by the Secretary for the proper and efficient administration of the plan” (referring to the Medicaid state plan). In addition, OMB Circular A-87, which contains the cost principles for State, local and Indian tribal governments for the administration of federal awards, states that, “Governmental units are responsible for the efficient and effective administration of federal awards.” Under these provisions, costs must be reasonable and necessary for the operation of the governmental unit or the performance of the federal award.

None of the FTEs projected for this Demonstration’s cost claiming is projected to have a portion of their time also billed as direct medical services.

The principle of being necessary for the proper and efficient administration of the Medicaid state plan has been addressed in two ways; 1) the use of detailed codes with daily electronic timekeeping for a small, designated group of employees, and 2) for the Care Coordinators with a less diverse set of job functions, periodic certification will be provided.

### 2. Parallel Coding Structure: Demonstration and Non-Demonstration Codes for Each Activity

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The activity codes will capture all of the activities performed by the participants and will distinguish Demonstration activities from similar activities that are not Demonstration reimbursable. This can be accomplished through the use of “parallel” activity codes. Using a parallel coding structure ensures that the codes capture 100 percent of the time spent and allocates it to the appropriate program activity. All staff in the administrative support/leadership group will be trained on proper procedures, including reporting activities under the parallel codes, before the documentation period begins.

### 3. Duplicate Payments

Federal, state and local governmental resources should be expended in the most cost-effective manner possible. In determining the administrative costs that are reimbursable under the demonstration, duplicate payments are not allowable. That is, states may not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative mechanism or funding source. The state must provide assurances to CMS of non-duplication through its administrative claims and the claiming process. Furthermore, in no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost of that program or claiming unit, including state, local, and federal funds. The state may dispute CMS’s position on what is a duplicate payment through appeal of any disallowance to the Departmental Appeals Board (DAB).

Examples of activities for which the costs may not be claimable as demonstration administration due to the potential for duplicate payments:

- Activities that are integral parts or extensions of direct medical services, such as the cost of any consultations between medical professionals, that is already reflected in the payment rate for medical cost claiming and may not be claimed separately as an administrative cost.
- An activity that has been, or will be, paid for as a medical assistance service (or as a service of another (non-Medicaid) program) (See section II. C., principle 6. on performing direct services vs. administrative activities).
- An activity that has been, or will be, paid for as a Demonstration administrative cost.

It is important to distinguish between duplicate payments for the same activity and the inefficient use of resources, which may result in the unnecessary performance of an activity more than once. Coordination of activities is intended to mitigate the duplicate performance of services or administrative activities, and is discussed in section II.C., principle 4, Coordination of Activities.

### 4. Coordination of Activities

In addition to avoiding duplicate payments, as discussed above in section II.C., principle 3., duplicate performance of activities should also be avoided. Under section II.C., principle 1., allowable administrative activities must be necessary “for the proper and efficient administration” of the program, as well as for the operation of all governmental programs. Therefore, it is important in the design of the Demonstration administrative claiming programs

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that MetroHealth not perform activities that are already being offered or should be provided by other entities, or through other programs. As appropriate, this calls for close coordination between MetroHealth, the state Medicaid agency, other state agencies, providers, community and non-profit organizations, and other entities related to the activities performed. The state must ensure that appropriate coordination occurs among providers.

The following are examples of activities that should be coordinated:

- State Medicaid agency would coordinate with respect to their payments to providers and third party payers to ensure that duplicate payments are not made for medical services claims under the demonstration program for its covered enrollees.
- State Medicaid agency would ascertain whether an administrative activity should be provided/ conducted by another governmental component rather than the demonstration, such as the production and release of demonstration materials.

5. Performing Direct Services v. Administrative Activities, and Care Coordination

The MetroHealth System will perform both direct services (e.g., medical care for covered benefits) and administrative activities (as listed in section II.C.7.). The documentation requirements and activity codes must capture and clearly distinguish direct services from administrative activities. Typically, direct services have different funding sources, claiming mechanisms, and documentation requirements related to each program or type of activity, and therefore they should not be claimed as an administrative expense.

As indicated in section II.C., principle 3., payments for allowable demonstration administrative activities must not duplicate payments that have been, or should have been, included as part of a direct medical service, capitation rate, or through some other state or federal program (as specified in OMB circular A-87). It is the state's responsibility to ensure there is no duplication in a claim prior to submitting the claim to CMS. Activities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service, and therefore they should not be claimed as an administrative expense. For example, when a MetroHealth physician provides a medical service to a demonstration enrollee, the practitioner should not bill separately for the cost of a referral as an administrative expense. These activities are properly paid for as part of the medical service and reimbursed at the federal medical assistance percentage (FMAP). Nor may these activities be claimed as an additional cost through administrative case management. The State Medicaid Manual (SMM) Section 4302 identifies certain activities that may be properly claimed as administrative case management. An allowable administrative cost must be directly related to a demonstration program service, and be necessary for the "proper and efficient administration" of the plan. Examples of administrative case management services are care coordination performed by the MetroHealth System. FTEs are designated Care Coordinator FTEs at patient-centered medical homes, within the emergency department, for disease registries, and as a demonstration enrollee transitions between inpatient, outpatient, and community care services.

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6. Allocable Share of Costs

Since some MetroHealth activities are provided both to the Demonstration and non-Demonstration population groups, the costs applicable to these activities must be allocated to both groups. This allocation of costs involves the determination and application of the proportional share of demonstration patients to the total number of patients. Development of the proportional demonstration share is referred to as the allocable share. The proportional demonstration share is then applied to the total costs of the specific activity, for example, Administrative Case Management Care Coordination, for which MetroHealth is submitting claims for FFP. This process is necessary to ensure that only the costs related to demonstration eligible patients are claimed.

Please see section 2.C.7 Activity Codes Descriptions and Examples for details. The universe of activity codes must capture the following categories of costs:

- Proportional Demonstration Share - the activity is allowable as administration under the Demonstration program, but the allocable share of costs must be determined by applying the percentage of the demonstration eligible population for each activity; or
- Total Demonstration Share - the activity is solely attributable to the demonstration program and as such is not subject to the application of the demonstration share percentage (this is sometimes referred to as “not discounted”);
- Unallowable - the activity is unallowable as administration under the demonstration program.

All costs related to documentation and documentation requirements will be supported by accounting records such as time studies, paid invoices, canceled checks, payrolls, contracts, journal entries and other plausible allocation methods.

- a) Salaries and Benefits - Timekeeping will be prepared and approved by the employee as being a true statement of activities. MetroHealth will retain the documentation for review by the State and CMS. The benefit rate will be 22 percent of related salaries based upon the overall benefit rate for MetroHealth.
  - (1) The positions for which salaries and benefits of FTEs are projected for administrative cost claiming are limited to those anticipated to perform any notable amount of demonstration program administration. As noted earlier, the State Medicaid agency will not be adding administrative capacity and will rely upon MetroHealth for the administration of the demonstration.
  - (2) Examples of the key job functions per position that are initially projected for FTE-allocation to the demonstration administrative cost claiming are below:



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- a. Executive Director – Managed Care Programs:
  - i. Designs and manages the demonstration program for MetroHealth, oversees staff, and meets with the State, CMS, and other stakeholders.
  - ii. Oversees the functions performed by the Demonstration’s Third Party Administrator
  - iii. Manages the contracted providers within the demonstration provider network external to The MetroHealth System
  - iv. The functions performed by the Executive Director – Managed care programs are similar to what a State Medicaid Agency staff person would do to operate the demonstration. For example, a State Medicaid Agency staff person would be required to spend time designing the demonstration, including working with individuals internal and external to the agency to determine the types of services to be offered, eligibility criteria, and network parameters, while creating policies and procedures for operating the demonstration. The state Medicaid agency staff person would also be required to manage the demonstration once it is operational, including maintenance of service operation, eligibility determination, network sustainability, and internal procedures necessary for the demonstration’s success. The state Medicaid agency staff person would also be required to oversee the functions performed by the demonstration’s Third Party Administrator, if the state were to choose to contract with one.
  - v. No portion of the Executive Director – Managed care programs’ time will be directed at providing direct services to beneficiaries.
  
- b. Managed Care Medical Director
  - i. Defines and oversees application of demonstration medical management criteria
  - ii. Determine medical necessity and provider coverage for covered benefit determinations
  - iii. Manages covered service and appeals
  - iv. The functions performed by the managed care medical director are similar to what a state Medicaid agency staff person would do to operate the demonstration. For example, a state Medicaid agency staff person would be required to spend time defining and overseeing application of demonstration medical management criteria to ensure the safe and appropriate delivery of health care services under the demonstration. The state Medicaid agency staff person would also be required to determine medical necessity for services offered under the demonstration and to establish guidelines for demonstration and network provider coverage for such services. Lastly, the state Medicaid agency staff person would manage the services provided

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- under the demonstration and appeals related to service denial or limitations.
- v. The managed care medical director's time is budgeted for approximately 0.6 FTE for the demonstration. No portion of this time will be directed to provide direct services to beneficiaries.
- c. Manager of Patient Population Analytics (a.k.a., Analyst)
- i. Designs and produces standard and ad hoc reports, workflows, and utilization/cost analyses on the demonstration's operational performance
  - ii. Collaborates with demonstration-contracted FQHCs and patient-centered medical homes
  - iii. Produces and administers program effectiveness measures, budget neutrality assessments, and other reporting to the state and CMS
  - iv. The functions performed by the Manager of patient population analytics are similar to what a state Medicaid agency staff person would do to operate the demonstration. For example, a state Medicaid Agency staff person would be required to spend time designing and producing reports, workflows, and utilization/cost analyses to demonstrate the operational performance of the demonstration and to exemplify to CMS the demonstration's operational sustainability. The state Medicaid agency staff person would also work with FQHCs and patient-centered medical homes within the demonstration's network to ensure stability in the relationship and to ensure these providers are also measuring their operational performance related to participation in the demonstration. The state Medicaid agency staff person would additionally be required to establish and administer metrics to measure program effectiveness, budget neutrality, and other demonstration requirements necessary to be shared with CMS.
  - v. No portion of the manager of patient population analytics' time will be directed at providing direct services to beneficiaries.
- d. Medicaid Waiver Program Business Analyst
- i. Manages administrative budget detail and cost allocation documentation
  - ii. Prepares demonstration financial reports, verifies TPA report data, and applies cost claiming protocols
  - iii. Compares actuarial model to actual demonstration experience
  - iv. The functions performed by the Medicaid waiver business analyst are similar to what a state Medicaid agency staff person would do to operate the demonstration. For example, a state Medicaid agency staff person would be required to spend time managing the

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demonstration's administrative budget and cost allocation documentation, in order to ensure compliance with demonstration requirements. The state Medicaid agency staff person would also prepare necessary financial reports and verify the TPA report data, and then apply cost claiming protocols to ensure compliance with Medicaid administrative claiming principles. The state Medicaid agency staff person would additionally compare the actuarial model to the actual demonstration experience.

- v. No portion of the Medicaid waiver program business analyst's time will be directed at providing direct services to beneficiaries.

e. Eligibility Researchers

- i. Conduct financial counseling to assist demonstration enrollees, under the direction of the director of Patient Access and Eligibility Services
- ii. Gather and maintain data to generate accurate demonstration enrollee lists for use by MetroHealth, third party administrator, pharmacy benefits manager, and the state
- iii. Documents and manages completion of demonstration application and eligibility document verifications
- iv. The functions performed by the Eligibility Researchers' are similar to what County Department of Job and Family (CDJFS) staff people would do to operate the demonstration. County Departments of Job and Family Services are the entities in Ohio that determine Medicaid eligibility on behalf of the single state Medicaid agency and assist individuals in applying for Medicaid. For example, CDJFS staff would conduct financial counseling to assist demonstration enrollees in determining their eligibility for participation in the demonstration. CDJFS staff would also facilitate completion of the demonstration applications and presumptive eligibility document verifications, and will document this work.
- v. No portion of the eligibility researchers' time will be directed at providing direct services to beneficiaries.

f. Care Coordinators

- i. Manage care navigation for demonstration enrollees in patient centered medical homes, emergency department, and during transition from inpatient care
- ii. Assist patients to improve compliance with care
- iii. Extract and assess data to maintain disease management registries for demonstration enrollees
- iv. The functions performed by the care coordinators are similar to what an Administrative Services Organization (ASO) would do to operate the demonstration. For example, an ASO staff person would manage

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a demonstration enrollee's navigation of care options and compliance with directives indicated by health care professionals, and extract and assessing data to maintain disease management registries.

No portion of the care coordinators' time will be the provision of direct services to beneficiaries. The activities described above will not be claimed as service costs. All activities will be claimed as administrative costs. These services are directly related to provision of waiver services and are necessary for the proper and efficient administration of the waiver. The state and MetroHealth will ensure that there is no duplication of claiming because care coordination is not offered as a direct service under the demonstration; the only care coordination offered under the demonstration is administrative.

- Consulting Services – Invoices or check requests will be properly approved along with documentation of the relationship to the demonstration.
  - (1) Examples of consulting services engaged by MetroHealth are noted below along with examples of their responsibilities:
    - a. Optumas – Analyze actual enrollee data against target population; deliver technical guidance on tracking financials aligned with actuarial model; provide assistance on operational data to assess budget neutrality progress
    - b. Vorys Health Care Advisors – Provide refinement recommendations for demonstration operations as well as policy and procedure enhancements; deliver technical guidance on transition planning; assist in facilitating evaluation and reporting
    - c. Other consultants for demonstration (e.g. legal, enrollment outreach, transition planning) - Assessment of demonstration program responsibilities; development of grievance and appeals process; preparation of demonstration contracts with the state, third party administrator, and external providers; outreach to eligible individuals to encourage enrollment/application; planning and actions to support transition of enrollees for demonstration conclusion).
  - b) Purchased Services – Invoices or check requests will be properly approved and the appropriate percentage related to the demonstration will be clearly documented. Purchased services are services that are specific to the demonstration and not used under any other MetroHealth program.
    - (1) Only administrative costs associated with the implementation phase will be claimed.
    - (2) Examples of purchased services engaged by MetroHealth are described below along with examples of their responsibilities:

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- a. Medical Mutual, third party administrator (TPA) – production of marketing outreach collaterals; production and distribution of enrollee identification cards and welcome/ education materials; benefit design coding and maintenance; enrollee customer service; medical management support functions; provider contracting; claim adjudication; medical cost data reporting to MetroHealth.
  - b. Caremark, pharmacy benefits manager (PBM) – a subcontractor to the TPA; maintenance of demonstration formulary; coordination with demonstration network pharmacies for covered benefits; 340b and non-340b prescription administration.
  - c. Walgreens, extended pharmacy network – 340b administration; pharmacy site administration and cooperation with PBM; reporting of 340b and non-340b covered prescriptions.
  - d. Eliza Corporation, enrollee engagement outreach – telephonic contact to alert new demonstration enrollees of program materials sent to their residence; follow-up with enrollees to confirm receipt of materials and engage focus on program; reporting on enrollee confirmation data.
  - e. Other consultant, for eligibility verification – temporary staff or firms hired by MetroHealth to assist financial counseling department on documents needed for eligibility applicants; outreach to secure eligibility documentation for eligible individuals and enrollees; reporting to MetroHealth on barriers and outcomes.
- d) Other Expenses – Invoices will be properly approved and the appropriate percentage related to the Demonstration will be clearly documented.

All administrative costs claimed in the demonstration will be coded to the Demonstration Cost Center in the MetroHealth System internal financial data to ensure that these costs are handled appropriately and not claimed in the MetroHealth Medicaid cost report.

#### 7. Activity Codes Descriptions and Examples

For purposes of Ohio’s MetroHealth Care Plus section 1115 demonstration, the MetroHealth System will be required to report costs associated with demonstration administrative activities on the Ohio Medicaid hospital cost report (JFS 02930), schedule M3, in accordance with the CMS-approved cost claiming protocol. MetroHealth will report administrative expenses in accordance with the regulations governing reimbursement for allowable administrative expenses as stated in 2 CFR Part 225 (OMB Circular A-87) and applicable requirements set forth in CMS 15-1 Section 2313.2(E). When MetroHealth staff perform duties related to the administration of the demonstration, federal funds may be drawn as federal financial participation (FFP) for the costs

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of providing these administrative services. To identify the time allocation and associated costs of providing these services, a time study, or an acceptable substitute system, must be conducted.

The indicators below, which follow each Code, provide the application of the FFP rate, the allowability or non-allowability designation, and the proportional demonstration share status of the Code:

Application of FFP rate

50 percent = Refers to an activity that is allowable as administration under the demonstration program and claimable at the 50 percent non-enhanced FFP rate.

Unallowable Activities

U = Refers to an activity that is unallowable as administration under the demonstration program. This is regardless of whether or not the population served includes demonstration eligible individuals.

Application of Demonstration Share

TM (Total Demonstration) = Refers to an activity that is 100 percent allowable as administration under the demonstration program.

PM (Proportional Demonstration Share) = Refers to an activity which is allowable as administration under the demonstration program, but for which the allocable share of costs must be determined by the application of the proportional demonstration share (the demonstration eligibility rate), for example, the demonstration share is determined as the ratio of demonstration eligible patients to total patients for Care Coordinators.

The following are descriptions and examples of the administrative activity codes that will be used to document administrative costs incurred by MetroHealth and determine the rate at which those costs are attributed to allowable and reimbursable demonstration administrative services:

Code A: Demonstration Eligible Program Planning and Policy Development  
PM/50 percent FFP

Planning to develop strategies to deliver, monitor, and oversee demonstration program services, such as benefit design consulting and financial modeling/forecasting services. Related paperwork, or staff travel required to perform specific Code A activities can be included.

Examples of this code are:

1. Identifying gaps in coverage or duplication of services and developing strategies to improve the coordination and delivery of these services.
2. Developing strategies to increase or assess capacity and access for demonstration program.
3. Working internally or with others to assess or increase the cost effectiveness of the

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demonstration program.

Code AU: Unallowable Non-Demonstration Program Planning and Policy Development

Non-Demonstration planning to develop strategies to deliver, monitor, and oversee program services, such as benefit design consulting and financial modeling/forecasting services

Examples of this code are:

1. Identifying progress and policy improvements in programs other than the Demonstration program.
2. Developing strategies to increase or assess capacity and access for non-Demonstration enrollees.
3. Working internally or with others to assess or increase the cost effectiveness of the programs other than the Demonstration.

Code B: Demonstration Eligible Marketing, Outreach, Eligibility, and Enrollment  
TM/50 percent FFP

Targeted marketing and public outreach to provide information about program services and encourage eligible low-income persons to apply. Oral or written informing methods may be used. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities. Eligibility screening and enrollment processes and systems to identify and facilitate the enrollment of eligible low-income, uninsured persons into demonstration program coverage.

Examples of this code are:

1. Providing and presenting materials to explain demonstration service that are available to demonstration eligible individuals.
2. Informing the general population for the purpose of generating interest in the demonstration program and informing community groups for the purpose of encouraging demonstration applications from eligible individuals.
3. Gathering information related to the application and verifying the individual's current eligibility status for purposes of the demonstration eligibility process.
4. Explaining Demonstration eligibility rules and requirements to prospective applicants.
5. Assisting individuals with completing a demonstration application.

Code BU: Unallowable Non-Demonstration Marketing, Outreach, Eligibility, and Enrollment

Non-demonstration marketing and public outreach to provide information about program services and encourage eligible low-income persons to apply. Non-demonstration eligibility screening and enrollment processes and systems to identify and facilitate the enrollment of eligible low-income, uninsured persons into non-demonstration covered programs.

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Examples of this code are:

1. Providing and presenting materials to explain services unrelated to the demonstration.
2. Informing the general population for the purpose of generating interest in other than the demonstration program and informing community groups for purposes other than the demonstration program.
3. Gathering information related to the application and verifying the individual's current eligibility status for purposes other than the Demonstration eligibility process.
4. Explaining eligibility rules and requirements to prospective applicants of programs other than the demonstration.
5. Assisting individuals with completing a non-demonstration application.

Code C: Demonstration Program Operation  
TM/50 percent FFP

Development and maintenance of data collection and quality monitoring systems that facilitate reporting and analyses. Data collection and analyses of reports, studies, or surveys required by CMS or Ohio Office of Medical Assistance. Developing, monitoring, and administering contracts or other arrangements with private and/or other public entities for delivery of services. Working in coordination with Third Party Administrator (TPA)/Pharmacy Benefit Manager (PBM).

Examples of this code are:

1. Collecting, analyzing, and reporting data related to demonstration enrollee utilization, medical costs, and enrollee quality of care.
2. Research for, analysis, presentation, and discussion of demonstration reports, studies, surveys required by CMS or the state.
3. Identifying providers suitable to offer demonstration covered services as prospects for contracts with the demonstration program. Negotiating provisions of demonstration contracts with providers of care and documenting and finalizing agreements with providers of care to participate with the demonstration program.
4. Establishing and overseeing TPA's or PBM's performance methods and results for demonstration program.
5. Training and directing TPA or PBM on service delivery to support demonstration program.
6. Creating contracts with and process documentation for TPA and PBM roles to support the Demonstration program.

Code CU: Unallowable Non-Demonstration Program Operation

Non-demonstration development and maintenance of data collection and quality monitoring systems that facilitate reporting and analyses. Non-demonstration data collection and analyses of reports, studies, or surveys required by CMS, Ohio Office of Medical Assistance, and other entities. Non-demonstration developing, monitoring, and administering contracts or other



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arrangements with private and/or other public entities for delivery of services. Working in coordination with non-demonstration Third Party Administrator (TPA)/Pharmacy Benefit Manager (PBM).

Examples of this code are:

1. Collecting, analyzing, and reporting data related to non-demonstration enrollee utilization, enrollee medical costs, and enrollee quality of care, other than that data required for comparison to the demonstration population to serve the demonstration program.
2. Research for, analysis, presentation, and discussion of non-demonstration reports, studies, surveys.
3. Identifying providers suitable for contracts other than with the demonstration program. Negotiating provisions of non-demonstration contracts with providers of care and documenting and finalizing agreements with providers of care to participate with non-demonstration programs.
4. Establishing and overseeing TPA's or PBM's performance methods and results for other than the demonstration program.
2. Training and directing TPA or PBM on service delivery to support other than the demonstration program.
3. Creating contracts with and process documentation for TPA and PBM roles to support other than the demonstration program.

Code D: Demonstration Eligible Training  
TM/50 percent FFP

Member education and training, such as production and distribution of benefits materials, and community and on-site information sessions to maximize use of the program.

Examples of this code are:

1. Developing, coordinating, and monitoring the education and training of demonstration enrollees on use of the demonstration program.
2. Training staff who conduct educational communications with demonstration enrollees on demonstration-related information.
3. Conferring with stakeholders, network providers, and the state about the demonstration enrollees' education and understanding of program benefits.

Code DU: Unallowable Non-Demonstration Training

Non-demonstration member education and training, such as production and distribution of benefits materials, and community and on-site information sessions to maximize use of the non-demonstration Programs

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Examples of this code are:

1. Developing, coordinating, and monitoring the education and training of non-demonstration enrollees.
2. Training staff who conduct educational communications with demonstration enrollees on non-demonstration-related information.
3. Conferring with stakeholders, network providers, and the state about member education of enrollees of programs other than the demonstration.

Code E: Demonstration Eligible Referral, Coordination, and Monitoring  
PM/50 Percent FFP

Care coordination and case management of demonstration enrollees.

Examples of this code are:

1. Managing outpatient care navigation for Demonstration enrollees in patient centered medical homes, emergency department, and during transition from inpatient care.
2. Assisting patients to improve compliance with care seeking compliance and use of demonstration benefits.
3. Extracting and assessing data to maintain disease management registries for demonstration enrollees.

Code EU: Unallowable Non-Demonstration Referral, Coordination, and Monitoring

Non-demonstration care coordination and case management of non-demonstration enrollees not separately reimbursed as a medical cost.

Examples of this code are:

1. Managing outpatient care navigation for non-demonstration enrollees in patient centered medical homes, emergency department, and during transition from inpatient care.
2. Assisting non-demonstration patients to improve compliance with care seeking compliance.
3. Extracting and assessing data to maintain disease management registries for non-demonstration enrollees.

Code FU: Unallowable Non-Demonstration Direct Medical Services

Non-demonstration activities related to providing care, treatment, and/or counseling services to an individual. This code also includes administrative activities that are an integral part of or extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, billing activities). This code also includes all related paperwork and clerical activities required to perform these activities.

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Examples of this code are:

1. Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports.
2. Providing direct clinical/treatment services.
3. Providing counseling services to treat health, mental health, or substance use disorders.
4. Providing immunizations.

Code G: General Administration Reallocated

Activities related to general administrative functions, paperwork, clerical activities, or staff travel required to perform demonstration activities, otherwise not assignable to a specific program activity under codes A through J above.

Examples of this code are:

1. Attending demonstration-related meetings, establishing long term program goals, reviewing MetroHealth procedures or rules related to demonstration.
2. Reviewing technical literature and research articles related to demonstration.
3. Providing general supervision of staff and evaluation of employee performance related to demonstration.

All demonstration administrative activities will be claimed at the 50 percent federal demonstration administrative matching rate.

The following crosswalk identifies the code set for each MetroHealth position:

1. Executive Director-Managed Care Programs-Codes A-G
  - Managed Care Medical Director-Codes A-G
  - Manager Patient Population Analytics-Codes A-G
  - Medicaid Waiver Program Business Analyst-Codes A-G
  - Eligibility Researcher-Codes A-G.

Administrative FFP for Skilled Professional Medical Personnel

In addition to the 50 percent federal demonstration administrative matching rate, section 1903(a)(2) of the Act provides for FFP at 75 percent for expenditures attributable to the compensation and training of skilled professional medical personnel (SPMP) of the State agency (See also 42 CFR 432.2, 432.45, 432.50 and 433.15.).

The state has not identified to CMS any activities under this demonstration that would be reimbursable at the enhanced 75 percent SPMP matching rate.

Note: Administrative costs incurred that are an integral part of, or an extension of, the provision of services by medical providers, are to be included in the rate paid by the date or its fiscal agent for the medical service. There is no additional FFP available.

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9. General Conditions

Under Ohio's MetroHealth Care Plus section 1115 demonstration, the state must:

- Obtain prior approval from CMS for any changes to the methodology used to capture or claim FFP for administrative costs associated with the demonstration
- Describe how it will offset other revenue sources for administrative expenditures associated with the demonstration, if applicable.
- Detail the oversight and monitoring protocol to oversee administrative claiming for the demonstration.
- Obtain prior approval for any new categories of administrative expenditures to be claimed under the demonstration.
- Agree to permit CMS to review any forms and/or documents that are subsequently developed for use by this program, prior to modification or execution.
- Submit all necessary changes to the demonstration administrative claiming plan to CMS for review and approval prior to implementation.

10. Cost Claiming and Adjustments

Monthly invoice to the state for Administrative Costs

On a monthly basis, all administrative costs will be summarized in the MetroHealth System internal financial data and billed to the state. Examples of demonstration administrative costs to be claimed include, but are not limited to, administrative costs directly related to demonstration activities in salaries, benefits, consulting services, purchased services and other expenses.

On a quarterly basis, the estimated salaries claimed will be adjusted. A reconciliation of estimated salaries claimed and actual salaries per the time reported will be prepared. An adjustment either will be claimed on the subsequent monthly invoice.

All other demonstration administrative costs will be processed through accounts payable into the demonstration's Administrative Cost Center. The state will report the administrative claim on the CMS 64 on a quarterly basis.