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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 22-0034

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 8, 2022

Maureen M. Corcoran, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

Re: Ohio State Plan Amendment (SPA) Transmittal Number 22-0034

Dear Ms. Corcoran:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number 22-0034. This amendment proposes to align Ohio's Alternative Benefit Plan (ABP) with the Medicaid state plan by adding the single pharmacy benefit manager pre-paid ambulatory health plan to the ABP.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that Ohio Medicaid SPA 22-0034 was approved on December 7, 2022, with an effective date of October 1, 2022.

If you have any questions, please contact Christine Davidson at (312) 886-3642 or via email at christine.davidson@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM
Tiffany Williams, ODM
Jan Covello, CMCS
Leslie Campbell, CMCS

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Ohio**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

22-0034

Proposed Effective Date

10/01/2022 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1937 of the Social Security Act, 42 USC 1396r-8

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2023	$ 0.00
Second Year	2024	$ 0.00

Subject of Amendment

Alternative Benefit Plan (SPBM-PAHP)

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  State Medicaid Director is the Governor's designee.

Signature of State Agency Official

Submitted By:	**Patrick Beatty**
Last Revision Date:	**Sep 30, 2022**
Submit Date:	**Sep 30, 2022**

Alternative Benefit Plan

State Name: Ohio Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: OH - 22 - 0034

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [x] Prepaid Inpatient Health Plans (PIHP).
  - [x] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ◉ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: May 11, 2018

Describe program below:

Ohio has provided managed care since 1978 and operated a mandatory enrollment program since 1989. The majority of Ohio's Medicaid beneficiaries are enrolled in a Medicaid Managed Care Organization (MCO). Around 2.8 million of the 3 million plus total Medicaid eligibles are covered under managed care. The managed care beneficiaries are comprised of Covered Families and Children (CFC), Aged, Blind, and Disabled (ABD) populations, including over 37,000 children with special healthcare needs. There are multiple MCOs serving Medicaid beneficiaries across the state. As a result, Medicaid managed care beneficiaries have greater choice when it comes to selecting an MCO that best suits their individual healthcare needs. The Office of Managed Care has primary oversight for the monitoring of the MCOs. Other areas within the Ohio Department of Medicaid (ODM) oversee managed care functions such as clinical, rate-setting, and financial performance monitoring and assessment. Managed care has been a means to improve access to healthcare, continuity and quality of care for Medicaid beneficiaries, provider accountability and cost predictability. As a supplement to Ohio's existing 1932(a) authority, effective July 1, 2013, Ohio added SSI children under the age of 21 to the Medicaid managed care program under a 1915(b) waiver approved by CMS. CMS has also approved a 1915(b)(c) waiver, for an effective date of March 1, 2014 that will allow the enrollment of Medicaid-Medicare duals in managed care through the Integrated Care Delivery System (ICDS) Demonstration.

☑ The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. No

MCO service delivery is provided on less than a statewide basis. No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: No

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Enrollment into a managed care organization is through an auto-assignment algorithm with a hierarchy of multiple steps that best matches needs and preserves existing provider-patient relationships. Enrollees new to the Medicaid system will be placed in a fee for-service pool prior to their auto-assignment. Enrollees have up to 90 days from initial enrollment to choose a different plan without cause and annually during the open enrollment period.

Additional Information: MCO (Optional)

Alternative Benefit Plan

Provide any additional details regarding this service delivery system (optional):

PIHP: Prepaid Inpatient Health Plan

The managed care delivery system is the same as an already approved managed care program. No

☑ The Alternative Benefit Plan will be provided through a prepaid inpatient health plan (PIHP) consistent with applicable managed care requirements (42 CFR Part 438, and section 1937 of the Social Security Act).

PIHP Procurement or Selection Method

Indicate the method used to select PIHPs:

◉ Competitive procurement method (RFP, RFA).

○ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PIHPs:

Other PIHP-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PIHP. Yes

List the benefits or services that will be provided apart from the PIHP, and explain how they will be provided. Add as many rows as needed.

Add	Benefit/service	Description of how the benefit/service will be provided	Remove
Add	Pharmacy Benefits	Pharmacy benefits are provided through the Single Pharmacy Benefit Manger (SPBM)	Remove
Add	Non-behavioral health services	Non-behavioral health services will be provided by the MCO benefit plan	Remove

PIHP service delivery is provided on less than a statewide basis. No

PIHP Participation Exclusions

Individuals are excluded from PIHP participation in the Alternative Benefit Plan: Yes

Select all that apply:

☐ Individuals with other medical insurance.

☐ Individuals eligible for less than three months.

☐ Individuals in a retroactive period of Medicaid eligibility.

☒ Other:

Describe:

PIHP participation is limited to individuals under age 21 with complex behavioral health and multi-system needs as indicated by a standardized assessment.

General PIHP Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

- (•) Mandatory participation.
- ( ) Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in PIHPs:

Additional Information: PIHP (Optional)

Provide any additional details regarding this service delivery system (optional):

As a part Ohio Department of Medicaid's (ODM) effort to launch the next generation of its managed care program, ODM will implement Ohio Resilience through Integrated Systems and Excellence (OhioRISE), a specialized managed care program for youth with complex behavioral health and multi-system needs. OhioRISE aims to shift the system of care and keep more kids and families together by creating new access to in-home and community-based services for children with the most complex behavioral health challenges.

On April 1, 2021, ODM selected Aetna Better Health of Ohio to serve as the new OhioRISE specialized managed care organization for the state's children with the most complex behavioral health and multi-system needs. Website link: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise

The selected OhioRISE plan operates under the authority of a 1915(b)(c) combination waiver as an at-risk Prepaid Inpatient Health Plan (PIHP) as defined in 42 CFR 438.2. The OhioRISE plan assumes risk for the cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payments under the contract. OhioRISE will feature intensive care coordination and both new and enhanced behavioral health services targeted toward this population along with offering a new Medicaid waiver program that will help families prevent custody relinquishment. OhioRISE will drive toward improving cross-system outcomes for its enrollees.

The OhioRISE plan will be paid a per member per month amount. ODM must pay the OhioRISE plan rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.4 (October 1, 2020), 42 CFR 438.5 (October 1, 2020), and CMS's Medicaid Managed Care Rate Development Guide. ODM's actuary will develop capitation rates for the OhioRISE plan that is "actuarially sound" for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. Costs include but are not limited to expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital and government mandated assessments, fees, and taxes.
Through the administrative component of the capitation rate paid to the OhioRISE plan by ODM, the OhioRISE plan will be compensated for the cost of the requirements found in these rules.

For the OhioRISE plan, the rates and actuarial methods will be found in Appendix M ("Rate Methodology") of the Medicaid OhioRISE Plan Provider Agreement. Website link: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise

The OhioRISE plan will partner with state agencies, providers, and community organizations to expand access to in-home and community-based services. Aetna will contract with regional care management entities to ensure OhioRISE members and families have the resources they need to navigate their interactions with multiple systems such as juvenile justice and corrections, child protection, developmental disabilities, mental health and addiction, education, and others.

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ( ) Section 1915(a) voluntary managed care program.

Alternative Benefit Plan

(•) Section 1915(b) managed care waiver.

( ) Section 1115 demonstration.

( ) Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Aug 8, 2022

Describe program below:

As a part of ODM's Next Generation of Managed Care initiative the Single Pharmacy Benefit Manager (SPBM) program was developed to improve management and administration of pharmacy benefits for Medicaid managed care beneficiaries while decreasing costs for the state. The SPBM is a specialized managed care organization contracted directly with ODM to administer Ohio Medicaid's prescription drug program. By directly contracting with ODM, the SPBM will provide ODM with greater ability to monitor quality, transparency and accountability in the pharmacy program. The SPBM will increase data accuracy and timeliness, supporting program integrity, quality, and pay-for-performance initiatives. Pharmacies will need to be enrolled with ODM to contract with the SPBM. ODM will also contract with a Pharmacy Pricing and Audit Consultant (PPAC) to oversee pharmacy reimbursement, benefit design, oversight and auditing. The PPAC will work in coordination with ODM and the SPBM to improve transparency, accountability, and efficiency within ODM's pharmacy benefits program. In addition, the PPAC will provide expert assistance and consultation, operational assistance, and liaison support to implement and enhance this operating model.

Medicare Dual Eligible individuals are excluded from the Medicaid managed care program and will therefore be excluded from enrollment in the SPBM. These individuals are either covered under Medicaid FFS or enrolled in the MyCare Ohio program, which are both excluded from enrollment in the SPBM at this time. Individuals enrolled in a Medicaid managed care organization that are receiving Medicaid under the adult extension category under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) who reside in a NF will be enrolled in the SPBM. All other individuals residing in a NF and/or ICF-IID are either covered under Medicaid FFS or enrolled in the MyCare Ohio program, are excluded from the Medicaid managed care program, and will therefore be excluded from enrollment in the SPBM. Individuals enrolled in the MyCare program will not be enrolled in the SPBM. Individuals enrolled in the OhioRISE plan (acting as PIHP) and enrolled in a Medicaid managed care organization will be enrolled in the SPBM. Individuals enrolled in an Ohio Department of Developmental Disabilities (DODD) home and community-based services (HCBS) waiver or the OhioRISE HCBS waiver that are enrolled in a Medicaid managed care organization will be enrolled in the SPBM. All other HCBS waiver individuals are excluded from enrollment in a Medicaid managed care organization and therefore will not be enrolled in the SPBM.

The SPBM's reimbursement structure is a set administration fee and a flat fee per claim once the program begins. Tiered dispensing fees will be utilized to reimburse pharmacies, and are determined at both the provider and medication level for all medications under the pharmacy benefit.

☑ The Alternative Benefit Plan will be provided through a prepaid ambulatory health plan (PAHP) consistent with applicable managed care requirements (42 CFR Part 438, and section 1937 of the Social Security Act).

PAHP Procurement or Selection Method

Indicate the method used to select PAHPs:

(•) Competitive procurement method (RFP, RFA).

( ) Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PAHPs:

Other PAHP-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PAHP. Yes

List the benefits or services that will be provided apart from the PAHP, and explain how they will be provided. Add as many rows as needed.

Add	Benefit/service	Description of how the benefit/service will be provided	Remove
Add	Physical health services	Physical health services will be provided by the MCO	Remove
Add	Behavioral Health Services	Behavioral health services will be provided by the MCO and PIHP when applicable	Remove

PAHP service delivery is provided on less than a statewide basis. No

PAHP Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan: No

General PAHP Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

- (•) Mandatory participation.
- ( ) Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in PAHPs:

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- (•) Traditional state-managed fee-for-service
- ( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The FFS delivery system is used as a transitional method for delivering care to the Adult group until they are enrolled in one of the Ohio Medicaid managed care plans (MCPs). The FFS delivery system offers the same services as provided by the MCPs.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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