
Refer to: MPC5

November 25, 2003

Barbara Edwards, Deputy Director
Office of Ohio Health Plans
Ohio Department of Job & Family Services
30 East Broad Street, 31st Floor
Columbus, OH 43215-3414

Dear Ms. Edwards:

We have reviewed Ohio's request to amend the PremierCare waiver, which you submitted to the Centers for Medicare & Medicaid Services (CMS) on August 29, 2003. Pursuant to provisions at Section 1915(f)(2) of the Social Security Act, we are requesting additional information.

Section D: Cost Effectiveness

1. Please describe the State's enrollment assumptions regarding children, adults, and pregnant women used to develop the composite rate for the Medicaid population.
2. Please certify that when and if any of the one percent at-risk amounts are collected from the plans, the Federal share of the amounts collected will be immediately returned on the quarterly CMS-64 expenditure reports. The Federal share may then be reclaimed at the time any performance incentive payments are actually made from the dedicated account.

Standard Funding Questions

We are aware that the following questions were recently sent to you informally. It is now standard practice for CMS to include these questions with formal requests for additional information about Medicaid managed care waivers and state plan amendments. Please include your responses to these questions with your reply to the other questions contained within this request for additional information.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that the Managed Care Organizations (MCOs) in the PremierCare waiver retain 100 percent of the payments. Do the MCOs retain all of the Medicaid capitation payments? Do the entities participate in such activities as intergovernmental transfers (IGT) or certified public expenditure (CPE) payments, including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the MCOs are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)
2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan. Please

describe how the state share of the Medicaid capitation payment for the MCOs is funded. Please describe whether the State share is from appropriations from the legislature, through IGTs, CPEs, provider taxes, or any other mechanism used by the State to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid capitation payment. If any of the State share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the State verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to the MCOs.
4. Payments Under Risk Contracts Financial Question. Are there any actual or potential payments to MCOs, pre-paid inpatient health plans, pre-paid ambulatory health plans, or other providers under this waiver which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as disproportionate share hospitals, academic medical centers, or federally qualified health centers.) If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If managed care contracts include mechanisms such as risk corridors, does the State recoup appropriate amount of any profits and return the Federal share of the excess to CMS on the quarterly expenditure reports?

5. 1915(b)(3) financial question. Does any provider receive payments (normal per diem, diagnostic related group, fee schedule, global, supplemental, enhanced, other) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

This request for additional information stops the 90-day review clock (which expires on November 27, 2003) for rendering a final decision on whether or not to approve Ohio's request to amend the PremierCare waiver. The clock will restart at day one upon receipt of a full response to our request.

If there are any questions regarding this letter, please contact Cynthia Garraway at (312) 353-8583.

Sincerely,

/s/

Cheryl A. Harris
Associate Regional Administrator
Division of Medicaid and Children's Health

cc: Mike Fiore, CMS Baltimore
Cynthia Burnell, Ohio Bureau of Managed Health Care