

## Compiled Questions for the Ohio PremierCare Waiver Amendment

1. In Appendix D2.A, please describe more fully CMS line item 4A, Mechanized Systems, Not Approved Under MMIS Procedures: Cost of in-House Activities, \$4,442,046. Are these costs reflective of other purchased or developed software packages?

*The charges on this line item are, in general, MIS costs allocated to Medicaid/SCHIP and further to the managed care program through the state's cost allocation plan. These costs include a portion of IBM (Ohio Data Network Charges) not charged to a specific program, a portion of MIS CRIS-E charges (our state's eligibility system), and MIS general administrative costs from the Office of MIS.*

2. What specific populations (e.g., adults, children) comprise the Title XIX Medicaid eligibility group? Are the costs of these specific populations very different? If yes, what assumptions were used to develop the composite rate for the base year and the upcoming waiver period in terms of costs and enrollment among these different populations?

*The Title XIX MEG includes MCO members in the Healthy Start and Healthy Families populations. These programs cover low income parents, pregnant women, and children. The cost experience for these populations is different. The base year composite rate for this MEG was developed based on actual enrollment during the base period. We do not expect significant variation in future enrollment distributions for these populations. Therefore, we do not expect significant variation in the composite rate for the Title XIX MEG due to a change in enrollment in upcoming waiver periods.*

3. Why is the PMPM lower for SCHIP?

*The SCHIP program covers only children. The capitation rates for children are lower than those for adults. This is demonstrated in historical Ohio fee-for-service experience. Therefore, the average capitation rate for the SCHIP MEG is less than the average capitation rate for the Title XIX MEG.*

4. What are the enhanced payments to contractor and providers referred to on page 100, Section D.B? How are these payments accounted for in the cost effectiveness calculations?

*The enhanced payments to MCOs referred to on page 100, section D. B represent the incentive payments that an MCO could receive for achieving a superior performance ranking. Per Appendix O of the ODJFS-MCO provider agreement*

*previously forwarded to CMS, ODJFS has established incentives which include the at-risk amount (included with the monthly premium payments) as well as possible monetary rewards up to \$250,000. Please refer to section D.H.d.1 for further detail on how these incentive payments are included in the cost effectiveness calculations.*

5. 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 providers retain 100 percent of the payments provided for in *Attachment 4.19-B (insert appropriate Attachment)*. Do providers retain all of the Medicaid payments (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, other) 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 providers 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 the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (ie, general fund, medical services account, etc.) For DSH payments, please also indicate if the State is making DSH payments in excess of 100% of costs and the percentage of payments in excess of 100% that are returned to the State, local governmental entity, or any other intermediary organization.

*This question is not applicable to the managed care program.*

6. 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 each type of Medicaid payment in *Attachment 4.19-B (insert appropriate attachment)* (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (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 each type of Medicaid 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).

*This question is not applicable to the managed care program.*

7. 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 each provider type *under Attachment 4.19-B (insert appropriate Attachment)*.

*This question is not applicable to the managed care program.*

8. *This is applicable to inpatient hospital, outpatient hospital and clinic services.* Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

*This question is not applicable to the managed care program.*

9. Does any public provider receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) *under Attachment 4.19-B (insert appropriate Attachment)* 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 question is not applicable to the managed care program.*