Ohio | Department of Medicaid

Ohio Medicaid Update

Ohio Association of Area Agencies of Aging (O4A) Preconference Intensive

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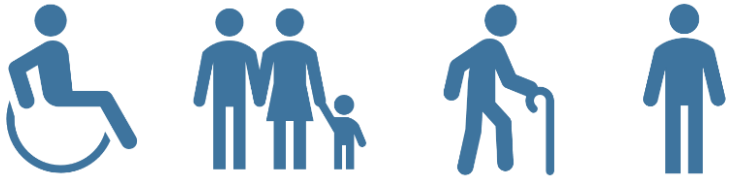
Ohio Medicaid & Managed Care

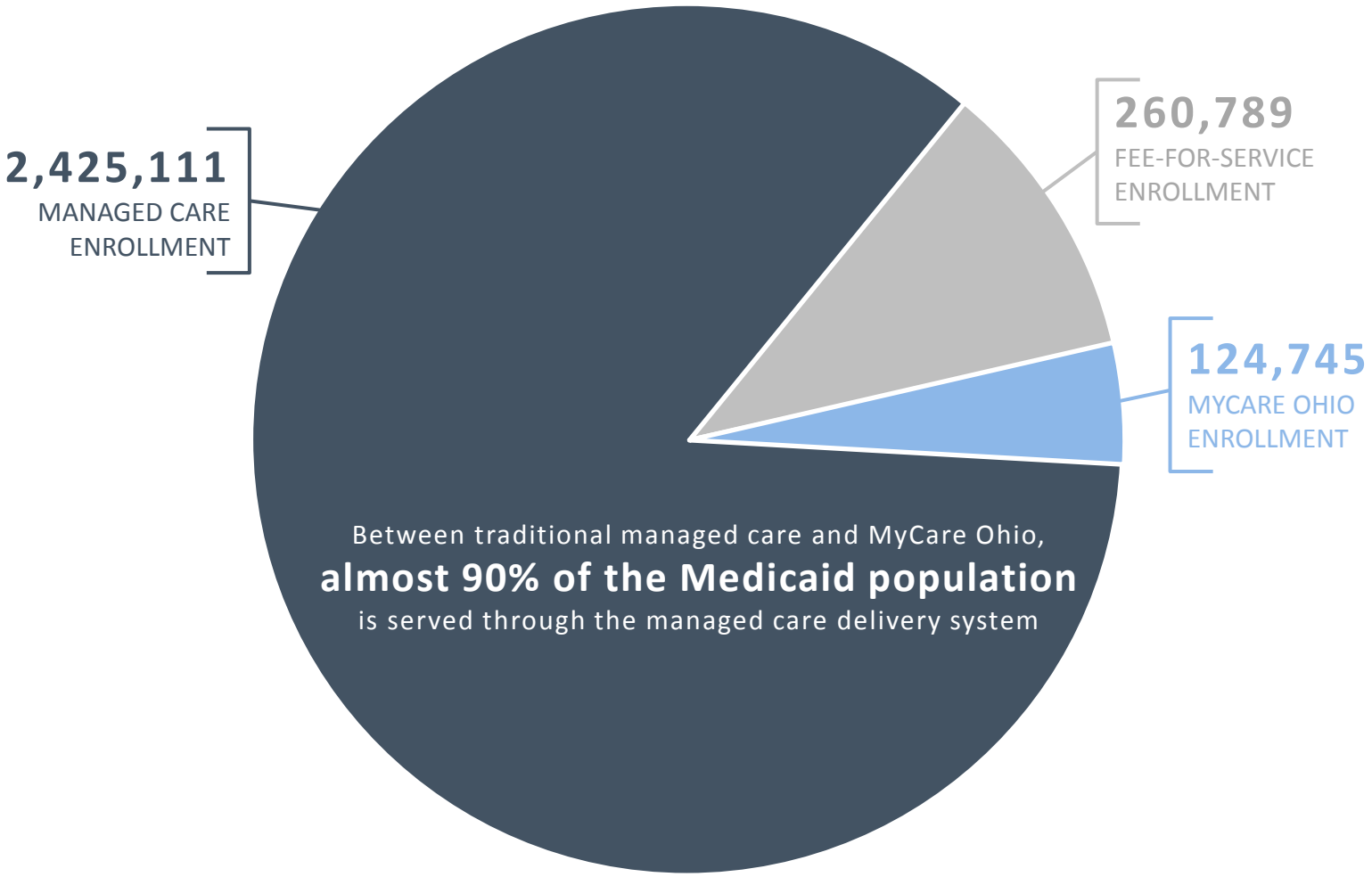
Medicaid is Ohio's **largest health payer.**



Provides health care coverage to nearly **3 million Ohioans.**

Network of **130,000 providers.**

Ohio Medicaid Enrollment



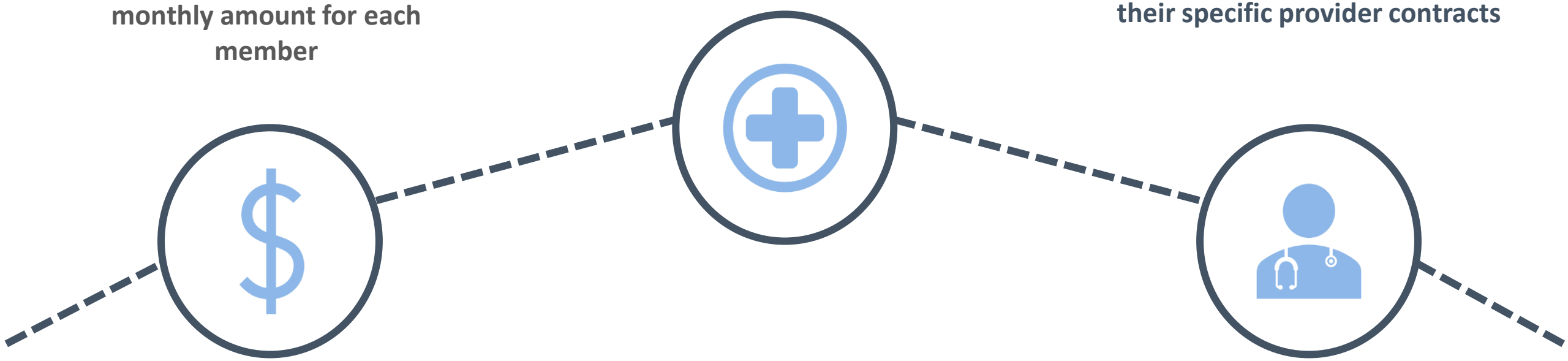
As of September 2019 - ODM Caseload Data (https://medicaid.ohio.gov/Portals/0/Resources/Reports/Caseload/2019/09-Caseload.pdf)

What is Managed Care?

Plans "manage" or arrange for the provision of Medicaid benefits for their members

ODM pays plans a set monthly amount for each member

Plans then pay providers based on their specific provider contracts



If the cost of care for a member is greater than the PMPM amount, the plan is responsible for covering the additional costs

Medicaid Managed Care Services

- MCPs work with hospitals, doctors and other providers to coordinate an individual's care and provide access to services
  - » At a minimum, all MCPs must cover the same benefits that Ohio Medicaid covers
  - » MCPs may offer additional services not normally available through traditional Medicaid coverage
- Individuals have the opportunity, during initial or open enrollment, to select the MCP that best fits their needs and meets their service requirements
- All traditional Medicaid managed care plans are statewide

Managed Care Benefit Package

Ohio's managed care program covers **primary** and **acute care** services mandated by the federal government, as well as optional services Ohio has chosen to provide:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services
- Laboratory and X-ray services
- Screening, diagnosis and treatment for children under age 21
- Immunizations
- Family planning services and supplies
- Home Health
- Private Duty Nursing
- Podiatry
- Chiropractic services
- Physical, Occupational, Developmental and Speech therapy services
- Durable medical equipment and medical supplies
- Nurse mid-wife
- Prescription drugs
- Ambulance or medical transportation
- Dental services

https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/ManagedCareBenefitPackage.pdf

Value Added Benefits

- MCPs add value for their members by providing services not normally offered in the traditional fee-for-service Medicaid program:

- Toll-free 24/7 nurse hotline
- Toll-free member services hotline
- Extended Office Hours (varies among plans)
- Grievance Resolution System

- Preventative Care Reminders
- Care Management to coordinate care

- Online, searchable provider directory
- Member Handbook
- Health Education Materials

- Expanded Benefits:
  - » Additional transportation
  - » Smoking Cessation
  - » Over the Counter Cards
- Participation Incentives

Benefits of Managed Care

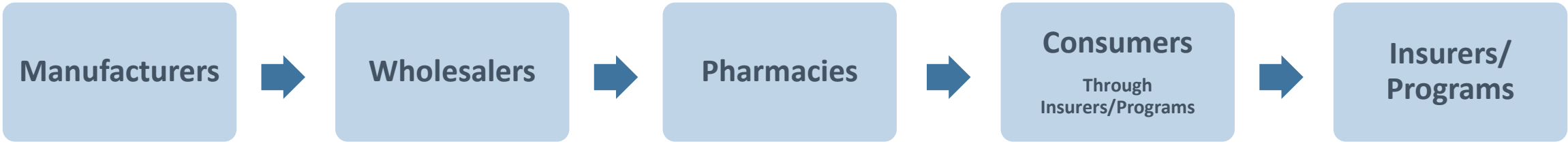
- Access to care and expanded provider network
- Value-based reimbursement
- Care management and coordination
- Long-term efficiencies
- Improved health outcomes by paying for quality
- Provider payment

Budget Initiatives

Summary of ODM Strategic Priorities

- **Transparency and Accountability**
  - » Maintaining discipline over our managed care vendors as we transition to the new system
  - » Using data to centralize accountability and provide transparency to our program
- **Long-term Services and Supports**
  - » Streamline waiver services to reduce burden on individuals, families, and providers
  - » Address the needs of aging Ohioans across agencies and programs with longer-term initiatives
- **Recovery Ohio**
  - » Improved opportunity for treatment and recovery options
  - » Increased focus on prevention and health promotion
- **Opportunity for Every Ohio Kid**
  - » Improved care coordination and outcomes for children served by multiple systems
  - » Increased access to behavioral health in schools
  - » Increased capacity for in-state treatment and support for children with complex needs

Increase Pharmacy Transparency – Managed Care Provider Agreements



- **Pass-Through Model –** January 2019
- **Enhanced Data Analytics** - January 2019
- **Eliminating Conflicts of Interest –** July 2019
- **Compliance Auditing of PBMs –** July 2019
- **Additional Disclosure Required in PBM Contracts –** July 2019
- **Promoting Safe and Effective Use of Medications** – July 2019
- **Unified Preferred Drug List –** January 2020
- **Single State PBM Vendor –** July 2020

Investing in Kids and Creating Healthy Moms

- Healthy Moms and Babies
  - » Creation of new maternal and infant support program – including home visiting services
- Continued Medicaid and Managed Care Plan investments in community infant mortality reduction efforts focused on reducing the disparity in African American poor infant outcomes
- Multi-System Youth Custody Relinquishment Fund through Ohio Family and Children First Council (FCFC) and in partnership with JFS other child-serving agencies
- Wellness for Kids through Comprehensive Primary Care (CPC) Lead Testing and Hazard Control

Stabilizing the BH System

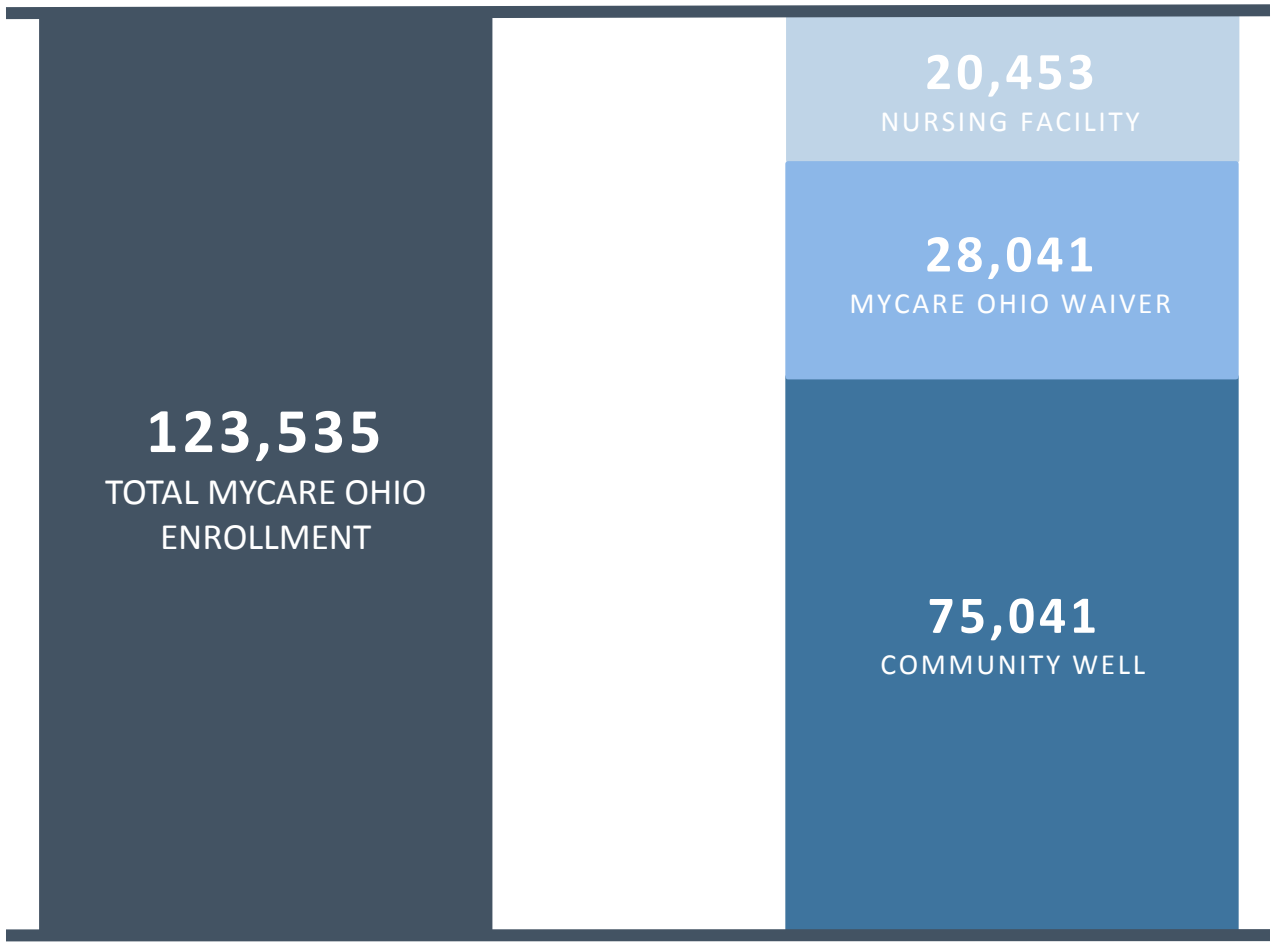
- Systems and data work to inform areas of needed intervention
- Focus has been on addressing claims payment delays and billing/coding issues
- Achieving stability in claims payment processes with the MCPs
- Support and technical assistance to individual providers with billing changes
- Transition requirement for MCOs
- Addressing stakeholder feedback concerns regarding BH Redesign
- Other managed care policy updates
- Recoupment/Repayment of provider advance payments

Additional Behavioral Health Initiatives

- Revised background check rule that aligns with OhioMHAS and professional licensing boards
- Behavioral Health Care Coordination
  - » Ohio Medicaid and OhioMHAS are committed to a behavioral health provider model of care coordination for adults and kids
  - » Goal: individuals care for the people who need it – there is not a “one size fits all” approach and within populations
  - » Looking at critical needs for:
    - Adults with serious and persistent mental illness
    - Adults and adolescents with substance use disorders
    - Multi-system youth and children with serious emotional disturbances
- Applied Behavioral Analysis (ABA) service for Autism Spectrum Disorders

MyCare Ohio Demonstration Program

MyCare Ohio Enrollment



MyCare Ohio

- Recently extended; new end date of Dec. 2022
- Largely, an “as-is” extension
- Changes include:
  - » Min. value-based contracting requirements with nursing facilities
  - » Performance improvement initiative to reduce long-term care providers admin. burden
  - » Technical modifications to the development of capitated rates
  - » Medicare quality withhold specific to diabetes control

CMS MyCare Ohio Evaluation Findings

- Data sources: interviews, beneficiary focus groups, CAHPS survey, Medicare claims data, the Minimum Data Set nursing facility assessments and MMP encounter data.
- Medicare – neither increased spending or reduced savings in early analysis, but plans reported savings. Medicaid analysis not yet avail.
- Care managers overwhelmed initially, struggled to meet deadlines, and members unaware of care manager.
- Ombudsman – very positive experience for members.
- Plans retained most providers after transition of care periods.
- Plans lacks of experience with LTSS and BH systems was a significant challenge early on, incl. payment delays.

Evaluation Findings – By the Numbers

- 21.3% reduction in inpatient admissions.

- 14.3% reduction in the probability of ambulatory care sensitive condition (overall) admissions.
- 13.2% reduction in the probability of ambulatory care sensitive condition (chronic) admissions.
- 15.3% reduction in skilled nursing facility admissions.
- However, preventable emergency room visits increased by 10.3 percent increase.

Challenges of CMS report and our solution

- Complexity of data (Medicaid $ analysis not yet available)
- Driven by CMS ⟶ they determine the focus
- Slowness of report: only one published so far

Recent My Care Ohio data analysis shows…

- 50% of MyCare Ohio statewide HEDIS results exceeded the 75th national NCQA Medicaid percentile.
  - » More than 25% of the rates exceeded the 90th national percentile benchmark
- Positive scores in the CAHPS survey in areas such as plan performance and member satisfaction.
- NCIID survey scores suggest the MyCare Waiver is performing better or equal to other waivers in most areas.
- Plans are approving about 90% of requested services from providers.
- Top 3 categories of grievances: billing, administrative issues and transportation.

Care Management Survey

***Data collected in 2018**

- Collaboration with ODM's External Quality Review Organization (EQRO) to understand MyCare Ohio plan care management program operations and service delivery from member's perspective*

- 70% reported being satisfied with their care manager

- 71% reported that a care plan was developed for them and of that percent:
  - » 93% reported participating in the development of their care plan
  - » 91% reported knowing the goals of their care plan
  - » 95% reported that their care manager reviewed their care plan with them
  - » 97% percent reported understanding their care plan

- *MyCare Ohio members were surveyed for this data

MyCare Updates

- MyCare enrollment issue
  - » Bug in MITS has prevented enrollment of a subgroup of eligible individuals
  - » Will be fixed in Nov
  - » Plans will see an increase in new members beginning late winter 2020 (tentatively)

- New financial management service
  - » New contract with Public Partnership LLC (a subsidiary of PCG) for FMS services
  - » Plans will contract with this entity as they did with Morning Sun for FMS in MyCare waiver

Waiver Alignment and Waiver Assessments

Current nursing facility level of care (NFLOC) waiver system creates

CONFUSION AND BARRIERS

for waiver recipients, providers, case management agencies, and managed care plans.

What is Waiver Alignment?

- Long-term goal of alignment of the four NFLOC waivers by establishing:
  - » One set of service definitions and specifications
  - » One incident management system
  - » One set of clinical practice standards
  - » One agency front door for waiver providers
  - » One monitoring system for waiver providers
  - » Participant direction in Ohio Home Care Waiver

- Rules will be maintained in a single Ohio Administrative Code (OAC) chapter that is the responsibility of Ohio Medicaid to maintain, in partnership with the Ohio Department of Aging.

Alignment of NFLOC waivers under ODM and ODM with consistent:

- Service definitions and specifications
- Incident management
- Clinical practice standards
- Monitoring of waiver providers

- MyCare Ohio
- Ohio Home Care
- PASSPORT
- Assisted Living

Alignment Processes and Tasks

- Stakeholder outreach
- ODA and ODM collaboration
- Updated Ohio's 1915(c) waivers
- OAC rule filing
- Budget implications and rate methodology work
- System Updates
- Training and communication for providers and individuals

Waiver Alignment to Date

Phase 1 (January 1, 2019)

- Alignment of 6 waiver services
- Alignment of rates (where applicable)
- Clinical practice standards alignment (ongoing work throughout all phases)

Phase 1.5 (July 1, 2019)

- Alignment of incident management process
- Development of single incident management system

Phase 2.0 (July 1, 2019)

- Alignment of 3 waiver services
- Including modifying waivers to capture HOME Choice

Waiver Alignment Next Steps

Phase 3.0 (proposed July 1, 2020)

- Alignment of 2 waiver services
- Consistent model of participant direction across waiver delivery system

Beyond Phase 3.0 (TBD)

- Continued alignment of waiver services
- One agency front door for providers, one monitoring system for providers

Adult Comprehensive Assessment Tool (ACAT)

The Adult Comprehensive Assessment Tool (ACAT): is a person-centered comprehensive case management and level of care assessment used to determine an adult's level of care and to assess the needs of the adult for purposes of enrollment on a NF-based home and community-based waiver

- Healthcare Electronic System(HENS) is being enhanced to implement all electronic assessment tools to evaluate consumers for services for the NF LOC based waivers.

Background

- ODM has developed updates to the nursing facility(NF)-based level of care rules.
- Changes to the level of care rules include implementation of new assessment tools to be utilized for NF level of care determinations, as well as NF-based waiver assessments.
- The Adult Level of Care Questionnaire(ALOCQ), Adult Comprehensive Assessment Tool(ACAT), Child Level of Care Questionnaire (CLOCQ) and Child Comprehensive Assessment Tool(CCAT) are the newly developed assessment tools to be utilized.

ACAT-Assessment Sections

- Section A: Individual Information
- Section B: Contact Information
- Section C: Legal Concerns
- Section D: Health Information
- Section E: Communication
- Section F: ADLs and IADLs
- Section G: Screenings
- Section H: School and Work
- Section I: Supports
- Section J: Adaptive/Assistive Equipment
- Section K: Environmental Review
- Section L: Primary Caregiver Assessments

Timeline

- **ACAT**- ALOCQ tool testing is underway with related algorithm. CLOCQ and CCAT will be launched at a later date.

- **ODA & ODM** - Implementation Planning in Process(identifying training needs, roles, responsibilities, methods/materials.

- **Adult & Child LOC -** Rules ready for final file. The plan is to reconvene the front door stakeholder group in the near future.

Managed Care Procurement


Focus on the
INDIVIDUAL
rather than the
business of
managed care
We want to do better for the people we serve

Some of our goals with this procurement are to:

Improve the quality of services and care to those we serve

Use best practices to expand quality services and improve health outcomes

Improve the provider experience in managed care

We want to think outside the box and explore innovative ideas.

This is a priority for Governor DeWine and Ohio Medicaid.

Medicaid Managed Care Procurement Project Phases

Current Phase

RFI #1 Feedback from Individuals & Providers

RFI #2 Feedback from Potential Bidders

RFA and Award

Implementation, Readiness & Post Implementation

We will work with individuals & providers in each stage.

Gather input and feedback from individuals and providers first

Gather input on capacity to address potential changes, based on feedback from individuals and providers

Communicate major milestones

Collaborate to ensure a smooth implementation and understand experience post implementation

Examples of what we've heard so far

PROVIDER EXPERIENCE

- Administratively burdensome
- Transparency
- Navigating prior authorization rules

INDIVIDUALS

- Increased dental coverage
- Ensuring access to care and supportive services
- Improved transportation

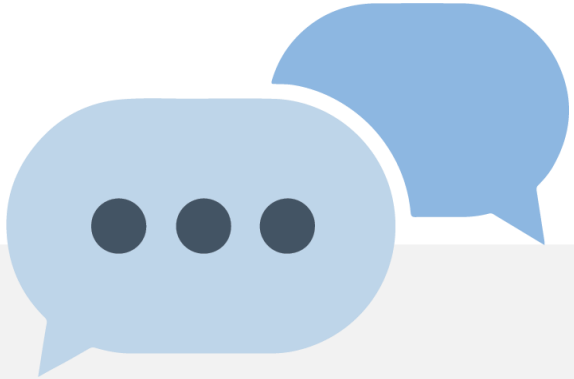
CHILDREN

- Need to improve care for children served by multiple agencies
- Coordination of care for children in rural areas
- Need to improve how services are delivered and coordinated for children in foster care

BEHAVIORAL HEALTH

- Claims payment
- Improved partnership with community based organizations

What we want to hear from the Individuals we serve



We are doing things differently.

- ✓Engaging stakeholders early in the process
- ✓Listening to individuals and providers first
- ✓Providing many ways for stakeholders to share input

1. **IDEAS**
   We want to hear your ideas and solutions.
2. **PERSPECTIVE**
   What is your experience with the current managed care program? What works and what doesn't?
3. **FEEDBACK**
   What else should we be thinking about?

A fillable PDF form is available at medicaid.ohio.gov/procurement

Email us at MCProcurement@medicaid.ohio.gov

Electronic Visit Verification

Electronic Visit Verification (EVV)

- Why did ODM implement an EVV system?
  - » Congress passed a federal law requiring State Medicaid programs to implement an EVV system for certain home and community-based (HCBS) services
  - » Law is commonly referred to as the 21st Century Cures Act
- What are the benefits of an EVV system?
  - » Improves quality of care by making workers' activities transparent and measurable
  - » Increases efficiency because reporting is automated and claims submission is cleaner
  - » Records individual worker's activity, which reduces the likelihood for error and fraud
- Additional information for individuals and providers can be found at www.medicaid.ohio.gov/evv

EVV Phase 1

- EVV Phase 1 went live 1/08/2018
- Included certain home and community based services for state plan and the Ohio Home Care waiver:
  - » State plan home health nursing and aide
  - » Private duty nursing
  - » Registered nurse assessment
  - » Ohio Home Care waiver nursing, personal care aide, and home care attendant

EVV Phase 2

- EVV Phase 2 includes ODA, DODD and managed care services:
  - » ODA – PASSPORT homecare attendant, personal care, and nursing
  - » DODD – Individual Options (IO) and Level 1 homemaker personal care and IO nursing
  - » Managed Care – home health nursing and aide, private duty nursing, MyCare Ohio waiver nursing, homecare attendant, and personal care aide
  - » Group visits will now be included across all payers

Phase 2 Provider Requirements

- Providers of Phase 2 services are required to use EVV beginning with dates of services on and after August 5, 2019
- Exceptions to Phase 2:
  - » Participant directed services
  - » Homemaker personal care services that are billed using the daily billing unit (DBU)
  - » On-site/on-call (OSOC)
  - » Shared living
  - » Residential/community respite
  - » Adult day and employment services

Phase 2 Implementation

- Timeline and activities for Phase 2 include:
  - » Outreach to providers began in 2018 and is ongoing
  - » Two letters were mailed to individuals receiving Phase 2 services explaining EVV
  - » Provider training offered May 6 – August 3, 2019 (limited number of classroom sessions added later in August)
- Phase 2 is being implemented collaboratively with DODD, ODA and the managed care plans to address program policy differences
  - » No individual verification is necessary for services provided through DODD waivers
  - » Claims will continue to be submitted in the same way to the same payers

County Collaboration and Engagement

County Collaboration and Engagement

ODM has realigned internal teams to be more focused on addressing the needs of counties and the people served:

- Centralized Ohio Benefits system management and providing integrated leadership with the claims payment system
- Created a unit focused on county engagement and ways to address the unique policy and operational needs of the counties
- Prioritizing reports needed by the counties for daily workflow management
- Bringing in county experts to serve as key advisors to leadership on county issues
- ODM is concentrating Central Processing Staff to provide direct support and relief to counties who need the greatest assistance

Enrollment and Eligibility and Process

- County Experience
  - » Survey results
  - » 7 County Visits
  - » Training
- Application and renewal processing
  - » Application backlog
  - » Redetermination backlog
  - » Eligibility error rate
    - Eligibility verification documentation missing
    - Late redeterminations due to incorrect redetermination date
    - Incorrect eligibility category/program (e.g. CHIP vs. Medicaid)
- Partnerships – ONE TEAM

HOME Choice

HOME Choice: History

Money Follows the Person Grant

- Opportunity from the Deficit Reduction Act of 2005
- Expanded under Affordable Care Act of 2010
- Grant enrollments from 2008 until December 31, 2018
- Transitioned 12,984 individuals
- Sustainability Plan
  - » Required by CMS
  - » Drafted by ODM and approved by CMS in 2015
  - » The basis of the new program July 1, 2019

HOME Choice: July 1, 2019

The same but different

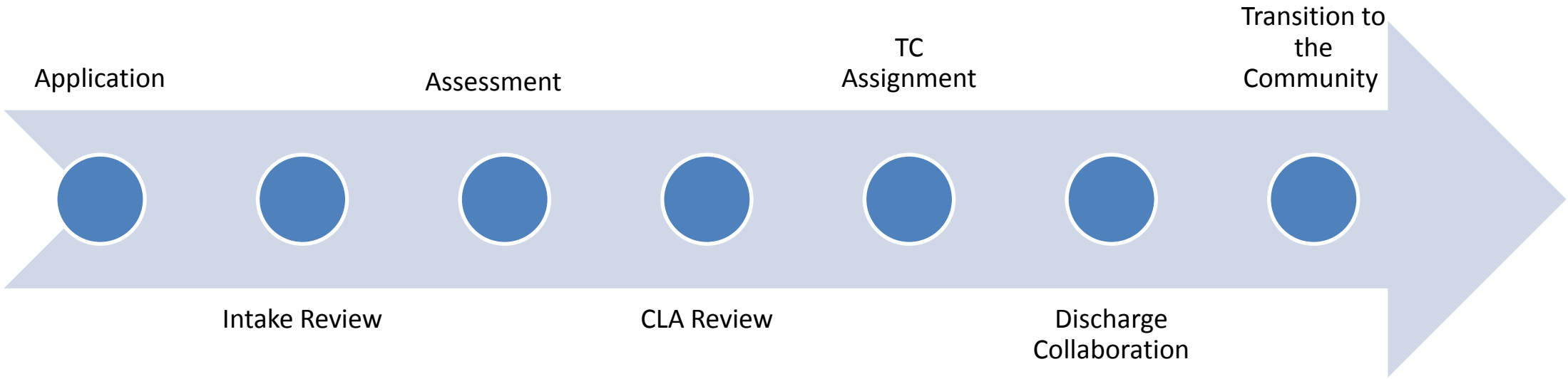
- Same name and mission
- Same populations - Physical Disabilities, Behavioral Health, Elderly and DD/ID
  - » DD/ID - 1/1/19 the IO Waiver contains transition services
  - » Individual under 18 years of age, excluded
- Six rules down to one
- 17 forms down to two
- Pared down services
- Pared down the provider network
- A ~~State funded~~ Grant Program

HOME Choice: Eligibility

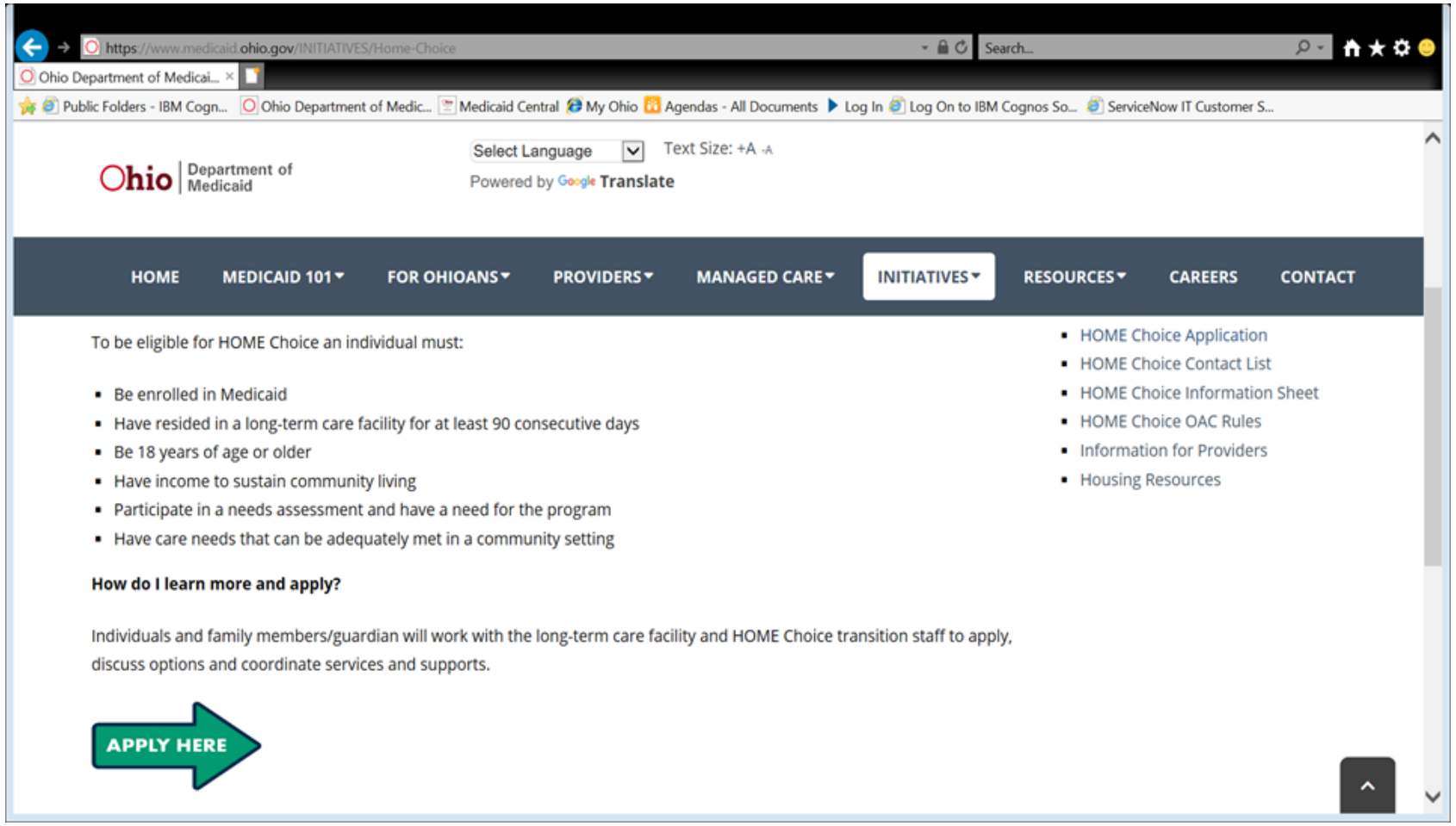
- Be enrolled in Medicaid
- Have resided in a long-term care facility for at least 90 day
- Be 18 years of age or older
- Have income to sustain community living
- Participate in a needs assessment for the program
- Have care needs that can be adequately met in the community

- OAC 5160-51-10

HOME Choice: Process



HOME Choice: Application



HOME Choice: Services and Supports

- **Assessment**
  - »In-Person
  - »Conducted by the OBLTSS network
  - »HOME Choice assessment tool
  - »Web application system
  - »Reviewed by HOME Choice CLA for enrollment determination

HOME Choice: Services and Supports

- **Transition Coordination**
  - »Collaboration with discharge planners and care team to determine services and supports needed in the community
  - »Assisting in locating housing
  - »Coordinating Community Transition Service
  - »Identifying other community resources
  - »Coordinating move to the community

HOME Choice: Services and Supports

- **Community Transition Service**
  - »OAC 5160-44-26
  - »Security deposits and rental expenses to obtain a lease
  - »Essential household items
  - »Fees and deposits for utilities and other services (e.g. phone, electricity, gas, water)
  - »Moving expenses
  - »Pre-transition transportation

HOME Choice: Services and Supports

HOME Choice Services	Non-Waiver Individual	Waiver Individual
Transition Coordination	Available to all Provided by program funding	Available to all Provided by program funding
Community Transition Service	Provided by program funding 180-day service Requires collaboration with HOME Choice CLA	Provided by waiver 180-day service Requires collaboration with Passport, Assisted Living, OHCW or MyCare Waivers

Ohio Department of Medicaid

Waiver CTS Authorization Template

☐ MyCare Waiver Expedited Request

Final Copy ☐
Receipts Attached ☐

Last Name	First Name	Medicaid ID Number
Program: MyCare Waiver	TC Agency or CTS Provider Name	Provider ID
Program Representative (PRINT)	TC or CTS Provider Contact	TC or CTS Provider Phone Number
Signature Approval and Date by Program Representative →		Program Representative Phone Number

DATE OF REQUEST	NECESSARY AND ALLOWABLE EXPENSE REQUESTED	ESTIMATED COST	APPROVED	DENIED	PROGRAM REPRESENTATIVE COMMENTS	DATE OF PURCHASE	ACTUAL COST
	Other:		☐	☐			
	Other:		☐	☐			
	Other:		☐	☐			
	Other:		☐	☐			
	Other:		☐	☐			
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	Other:		☐	☐			
	Other:		☐	☐			
	TOTAL ESTIMATED					TOTAL ACTUAL	

Per 5160-44-26 – Community transition services shall not exceed two thousand dollars per individual per waiver enrollment.

*Administrative Fee not allowable for HOME Choice individual.

Revised 9/5/19

HOME Choice: Post Transition

- **Transition Coordinator**
  - »Follows the individual in the community for 30 days
  - »Visits the individual within 14 calendar days
  - »Makes final CTS purchase requests and purchases
  - »Submits final CTS receipts to the CLA or waiver case manager
  - »Informs waiver case manager, MyCare care manager or Medicaid managed care case manager of any on-going issues or concerns

Ohio | Department of Medicaid

We look forward to working with individuals, advocates, and partners to better serve all Ohioans and future generations.