Ohio | Department of Medicaid

John R. Kasich, Governor
Barbara R. Sears, Director

O4A Conference

Ohio Department of Medicaid
11/1/2018

Agenda

- Ohio Medicaid Budget Update
- Priority work through the end of the Administration
- Managed Care & LTSS Collaboration Work
- MyCare Ohio
- Q&A

Budget Updates

Budget Updates

- Spending on the LTSS population was about $7.6 billion in FY18. This a *third of the total services* expenditure for Medicaid.

- For FY18, the state share of general revenue fund (GRF) spending in the 525 line item finished the fiscal year only $33.5 million under the estimate of $3.759 billion. *Less than 1% variance*.

- It is early in FY19, but the state share of spending from the 525 line item is under estimate by $42.7 through August. Caseload is running lower than anticipated, driving the underspend. (*Just under 3 million enrollees*)

  - » Overall caseload was 77,211 (-2.6 percent) under estimate for the month of August. Group VIII caseload has declined by over 50,000 since July 2017 and was below projections (-5.3 percent) for the month August.

- We have begun working on the FY20/21 budget. The Executive budget will probably be released in March 2019. State law allows for a later budget introduction due to the transition to a new Governor.

Priority Leadership Work

Priority Leadership Work

- **Behavioral Health Integration** – Ensuring stable environment in managed care for behavioral health services; Continuing work on behavioral health care coordination

- **Medicaid Work Requirements** – ODM is continuing to work with CMS on the work requirement waiver

- **Implementing New Pharmacy Contract Model** – pass-through pricing model for contracted Pharmacy Benefit Managers set to go into effect January 1, 2019

Priority Leadership Work (cont.)

- **Continuing Implementation of EVV** – ODM is taking a phased in approach to this initiative
  - Phase 1 - implemented in January 2018 for state plan Home Health services and Ohio Home Care Waiver
  - Phase 2 - expected to be implemented in in October 2019 for Managed Care and Aging
  - Phase 3 - expected to be implemented in 2020 for self direction and home based therapy services

- **SUD 1115 Waiver** – ODM is requesting an 1115 demonstration waiver to use IMDs as a Medicaid covered setting for SUD inpatient and residential treatment in both managed care and FFS for adults and children; expected implementation in 2019

Priority Leadership Work (cont.)

- **Waiver Alignment –** Phased in approach to this work potentially beginning in January 2019
  - One set of service definitions and specifications
  - Rate alignment
  - One incident management system
  - One set of clinical practice standards
  - One agency front-door for waiver providers
  - One monitoring system for waiver providers

- **MyCare Ohio –** Improvement and next steps

- **Transition Planning**

Managed Care & LTSS Collaboration

New Managed Care Resource Documents

- Developed resource documents that outlines MCP and MCOP requirements for NF admissions
  - » Prior Authorization (PA) and Level of Care (LOC) requirements are outlined
  - » Includes plan specific contact information and processes
- Four total resources: Common Terminology, NF-Based LOC FAQ, Managed Care FAQ and MyCare Ohio FAQ
- Resource documents have been posted on the ODM website - https://medicaid.ohio.gov/provider/ManagedCare/PolicyGuidance

Common Terminology Document

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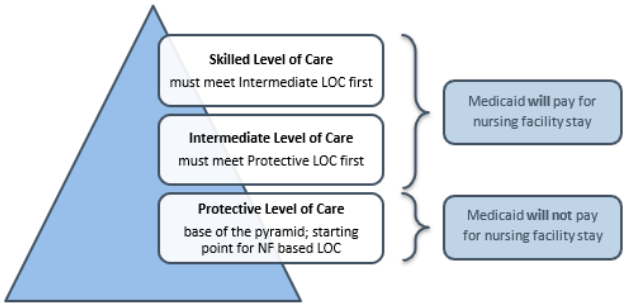
Nursing Facility Definitions – Common Terminology

MEDICARE DEFINITIONS

- **Custodial Care –** non-skilled, non-medical (personal) care, like help with activities of daily living like bathing, dressing, eating, getting in or out of bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do by themselves. The care can reasonably and safely be provided by non-licensed caregivers. Medicare will not cover custodial care if it is the only care an individual needs.
- **Skilled Care –** individual requires daily skilled care that can *only* be provided by or under the supervision of skilled or licensed medical personnel. Skilled rehabilitation is considered daily for the purposes of this definition if the individual is offered and utilizes the rehab services at least 5 days per week. *Individual must also meet additional eligibility requirements for Medicare to pay for the skilled nursing facility stay (please reference the Medicare website for more information).*

MEDICAID DEFINITIONS

- **Skilled Nursing Services –** means specific tasks that must, in accordance with Chapter 4723 of the Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.
- **Skilled Rehabilitation Services –** means specific tasks that must, in accordance with Title 47 of the Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel.
- **Protective Level of Care (LOC) –** described in OAC rule 5160-3-06; Medicaid will *not* pay for a nursing facility stay if the individual *only* meets a protective level of care
- **Intermediate LOC –** described in OAC rule 5160-3-08; Medicaid will pay for a nursing facility stay if the individual meets an intermediate level of care
- **Skilled LOC –** described in OAC rule 5160-3-08; Medicaid will pay for a nursing facility stay if the individual meets a skilled level of care



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Managed Care and NF-Based LOC FAQ

Frequently Asked Questions
Managed Care and Nursing Facility-Based Levels of Care

OHIO DEPARTMENT OF MEDICAID — SEPTEMBER 2018

Individuals seeking Medicaid payment for a nursing facility (NF) stay must have a nursing facility-based level of care (LOC) to ensure Medicaid payment for those services. NF-based levels of care are described in Ohio Administrative Code (OAC) rules 5160-3-05 and 5160-3-08. This document is specific to individuals who are enrolled in managed care at the time of a nursing facility stay.

What are the nursing facility based levels of care?

- **Intermediate Level of Care (ILOC)** – when an individual's need for long-term services and supports exceeds the criteria for protective LOC and the individual has a need for at least one of the following:
  - Assistance with two activities of daily living (ADLs);
  - Assistance with one ADL and medication self-administration;
  - A need for one skilled nursing or skilled rehabilitation service; or
  - A need for 24-hour support in order to prevent harm due to a cognitive impairment.
- **Skilled Level of Care (SLOC)** – when an individual's need for long-term services and supports exceeds the criteria for ILOC or the Developmental Disabilities LOC. The individual must also have an unstable condition and a need for either one skilled nursing service (per day, seven days a week) or one skilled rehabilitation service (per day, no less than five days per week).
- Either of the above levels of care meet the standard for Medicaid payment to a nursing facility per OAC rule 5160-3-08.

What is the role of the discharge hospital and/or admitting nursing facility?

When a Medicaid managed care plan (MCP) or MyCare Ohio plan (MCOP) member is transitioning from a hospital into a NF, the hospital and/or admitting NF must ensure the member meets PASRR requirements and must request prior authorization (PA) or LOC approval from the plan for the NF stay. The NF should be in-network unless otherwise approved by the plan. *(see MMC and MCOP PA/LOC FAQ documents for additional plan specific requirements).*

What is the role of the Area Agency on Aging (AAA)?

Unlike the fee-for-service (FFS) process, the AAAs do not have a state-defined role in the LOC determination process for NF admissions for individuals enrolled in an MCP or MCOP.

What documentation does the NF need to submit?

- For specific information related to each MCP and MCOP's authorization requirements for NF stays, see the separate PA/LOC FAQ document on ODM's website: **(insert link to MMC/MCOP FAQs)**
- When an individual receives Medicaid services through an MCP or MCOP, the hospital transitioning a member into a NF or the admitting NF shall notify the plan and request approval for the NF stay. A plan must ensure the NF-based LOC criteria are met and provide authorization upon admission to a NF. In order for a plan to complete the LOC process, the following specific documentation may be requested:
  - PASRR compliance documentation[1]*;
  - Clinical information (diagnoses, medications, MDS Section G, etc.);
  - Other documentation per plan request

[1] The nursing facility is responsible for ensuring PASRR requirements are met in accordance with OAC rules 5130-3-15, 5160-3-15.1 and 5160-3-15.2.

FAQ Managed Care and Nursing Facility-Based Levels of Care 1

Prior Authorization and Level of Care for NF Stays FAQs

Medicaid Managed Care

Prior Authorization and Level of Care for Nursing Facility Stays

OHIO DEPARTMENT OF MEDICAID — SEPTEMBER 2018

This guide is intended to be used by nursing facilities when an individual enrolled in a traditional Medicaid managed care plan (MCP) is admitted to a nursing facility (NF) and **Medicaid** is paying for the NF stay. Outlined below are the prior authorization (PA) processes for each MCP. The PA processes described below include a level of care (LOC) determination.

Is a Prior Authorization required for a NF stay?
Yes, a PA is required by every MCP.

What should the NF submit when requesting a Prior Authorizat
Clinical information (diagnoses, medications, current therapy notes, wound descri
protective LOC, discharge planning, etc.), any other pertinent information, and an

How does the NF request a LOC determination from the MCP?
There is not a separate LOC determination process. For members enrolled in an M
the prior authorization process using criteria for nursing facility-based level of care

What is the Prior Authorization determination process?
The MCP will complete a medical necessity desk review to determine the appropri
accordance with OAC rule 5160-3-08.

How long does it take to get a Prior Authorization decision fron
As outlined in ORC section 5160.34, expedited PA requests shall be decided within
shall be decided within 10 calendar days.

When are continued stay reviews (e.g. expiring authorizations)
MCPs will perform continued stay reviews when prior authorizations are expiring i
necessity for NF services. Level of care will also be reevaluated during a continued
date for the previous authorization on their determination letter. This is the date t
continued stay review completed. The authorization spans differ by plan but are e
determination letter.

Includes plan specific information as well!

Medicaid Managed Care – Medicaid Covered NF Stay – Plan Specific Information for Requesting PA

MCP Name	Buckeye	CareSource	Molina	United	Paramount
How does the NF request a PA from your plan?	PA request form is online: www.buckeyehealthplan.com/content/dam/centene/Buckeye/medicaid/pdfs/OH-PAF-0637_May2016_IP.pdf. Indicate what type of authorization requesting. A completed PA request with supporting documentation should be faxed to (866) 529-0291.	PA request form is online at www.caresource.com under the Provider Authorization section. Submit the PA form or equivalent documentation by email to snf@caresource.com, via eFax to (855) 262-9791, by voicemail to (937) 531-2014 or via the Provider Portal at https://providerportal.caresource.com/OH/.	PA request form is online: www.molinahealthcare.com/providers/oh/medicaid/forms/Pages/fuf.aspx. The PA request form should be submitted to (866) 449-6843.	PA request form is online at https://www.uhcprovider.com/en/prior-auth-advance-notification.html or the NF can contact our Prior Authorization Department at (800) 366-7304 (phone) or (866) 839-6454 (fax). **PA request should be made within 24 hours* of NF admission.** **To prevent a delayed hospital discharge, either the hospital or the NF can notify United of the NF admission. The NF should submit the PA request with updated clinical information (continued stay review) within 3 days of actual admission.*	PA request form is online: www.paramounthealthcare.com/documents/provider/SNF-PRECERT.pdf. Completed requests can be faxed to (567) 661-0848 or (844) 282-4908 or through the online portal www.myparamount.org.
What documentation will be sent to the NF following a PA request?	A PA approval letter is faxed to the facility.	PA Notification letter is sent to the facility with the case determination decision and other important authorization information.	Final determination is faxed to the NF for each PA request using an internal template document.	Verbal notification of decision to the NF, and communication log faxed to NF that includes important authorization information.	A correspondence letter either approving or denying the PA request will be sent to the NF, which includes a level of care determination.
What does the plan require from the NF when a member is going to be disenrolled & switch to FFS?	A face sheet[1] (showing the admission date of the member) and a "Letter of Intent"[2] from the facility should be faxed to (866) 529-0291 to demonstrate that there is no foreseeable discharge.	A face sheet and supporting documentation be submitted by eFax to (937) 396-3384 or by email to Disenrollment@caresource.com.	A face sheet (showing the admission date of the member) and a "Letter of Intent" from the facility should be faxed to (866-449-6843) to demonstrate that there is no foreseeable discharge.	A face sheet and discharge summary should be submitted to UHCCP's Utilization Management (UM) Manager who will coordinate needed documents.	A face sheet and a clinical review that supports continued need for NF level of care should be submitted via fax to (567) 661-0848 or (844) 282-4908.

[1] A face sheet is a document that provides demographic information about the individual and includes information on admission and/or readmission to a facility. This document demonstrates that the individual has been in the facility for a specific timeframe since a specific date.
[2] The "Letter of Intent" or supporting documentation required from each plan shall include information to support the individual's current level of care and need for continued NF placement.

Patient Liability Workgroup

- Workgroup formed to address issues with the current patient liability process
  - » Monthly meetings
  - » Managed Care plans, NF associations, Assisted Living Association, AAAs (waiver)
- New ODM position to mitigate PL discrepancies between NF and MCP using Ohio Benefits. Look for more information to come
- Limited vendor contract to review PL processes end-to-end
  - » Identify gaps and inconsistencies
  - » Analyze and recommend improvements to PL process
  - » Standardize and align PL processes across payer sources

Relevant Provider Agreement Updates

- Effective January 1, 2019, MyCare Ohio plans must share the following data with AAAs for wavier service coordination:
  - » Care plans;
  - » Most recent comprehensive assessment and due dates;
  - » Risk stratification and approved contact schedule;
  - » Claims including inpatient hospitalizations, emergency departments and waiver services; and
  - » Risk agreements, as applicable.

  - » Provider Agreements are on the ODM Website

Level of Care Assessment Updates

- Currently working in conjunction with the Ohio Department of Aging on one standardized assessment system
- Desire to move to a single case management system that would accompany the assessment system
- Assessment system will house the assessment tools for NF-based waiver programs
  - » Adult comprehensive assessment tool (ACAT)
  - » Child comprehensive assessment tool (CCAT)
  - » Adult level of care questionnaire (ALOCQ)

Waiver Alignment:

- Modernize Ohio's 1915(c) waivers in an effort to align with Ohio Medicaid's Overall Quality Strategy
- Align waiver functions based on lesson's learned in FFS and MyCare Ohio
- Achieve operational and administrative efficiencies throughout all waivers
- Improve the delivery system so that it is not fragmented and works well for members and providers regardless of the payer source

Waiver Alignment (Jan. 1, 2019)

- Alignment of six waiver services across Ohio Home Care, Passport and My Care Waivers

- OAC Chapter 5160-44
  - » ODM's 6 newly defined services will be in this chapter
  - » ODA will reference chapter 44 in their OAC chapter

- Does not include aligned waiver codes at this time
- JCARR in December

Proposed Aligned Services

- Home delivered meals (5160-44-11)
- Home modification service (5160-44-13)
- Personal emergency response system (5160-44-16)
- Out-of-home respite 5160-44-17
- Waiver nursing 5160-44-22
- Home Care Attendant 5160-44-27

Waiver Alignment: Rates

- Alignment of rates
  - » Home delivered meals
  - » Personal emergency response system
- Home delivered meals
  - » FFS rate of $6.50 per meal (Decrease for OHC and increase for PP)
  - » OHC now offers higher rate of $8.68 for therapeutic and kosher meals
  - » Establishes one statewide rate
- Personal emergency response system
  - » Statewide rate for installation and monthly service ($32.95 for each service)
  - » Eliminated partial month payments: no longer pay for replacement or additional pendants

Phase 1.5 – Incident management (2019)

- Working on a streamlined incident management process for Assisted Living, MyCare, OHC and PASSPORT:
  - » Provides a single list of incident types that must be reported and investigated
  - » Will hold a separate stakeholder meeting to fully review new incident management rule and processes (date TBD)

- Begin development of a single incident database:
  - » Incidents would be reported and monitored through the single incident database;
  - » Investigating DD incident system; and
  - » Implementation date unknown at this time – significant stakeholder input anticipated

MyCare Ohio

MyCare Ohio

- Initially a three-year demonstration project that was extended until December 2019
- Surveys and data sets show that MyCare Ohio has improved the lives of Ohioans
- Additional MyCare Ohio Extension request
  - » ODM has asked CMS for an additional extension to the demonstration until December 2022
  - » Extension request pending CMS approval
- More value-based arrangements are a priority

My Care Ohio data analysis shows…

- 59% of MyCare Ohio statewide HEDIS results exceeded the 75th national NCQA Medicaid percentile
  - » Compared to other Medicaid health plans on a national level, 59% of MyCare Ohio plans' HEDIS results are in the top 25%
  - » LTSS specific data measures are desirable
- 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
- MyCare Ohio has helped with rebalancing efforts

My Care Ohio: 2017 Care Management Survey

- Collaboration with Health Services Advisory Group (HSAG) to understand MyCare Ohio plan care management program operations and service delivery from member's perspective*
- 70% reported being satisfied with their care manager
- 68% reported that a care plan was developed for them and of that percent:
  - » 92% reported participating in the development of their care plan
  - » 90% reported knowing the goals of their care plan
  - » 95% reported that their care manager reviewed their care plan with them
  - » 96% percent reported understanding their care plan

*MyCare Ohio members were surveyed for this data

Questions or Gripes?