Ohio | Department of Medicaid

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

Ohio Medicaid: Managed Care Updates

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Background

- Approximately 3 million individuals are insured under Medicaid making it Ohio's largest health payer
- There are over 83,000 active providers, hospitals, nursing homes and other providers delivering services to individuals insured through Medicaid
- Approximately 2.4 million individuals are served by five (6) statewide managed care plans (MCPs)*

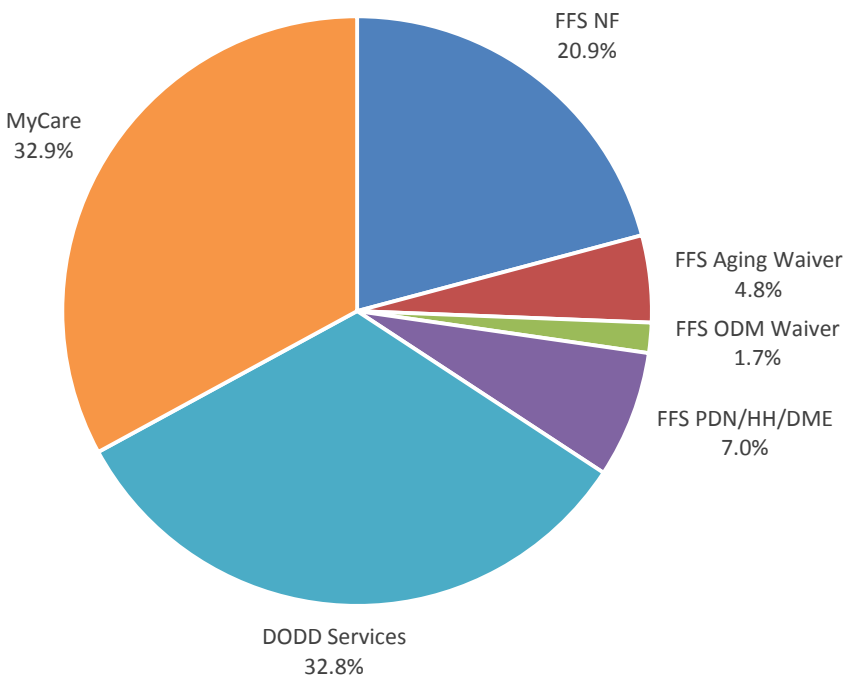
*Aetna was added as a MyCare Ohio Plan

Medicaid Facts and figures

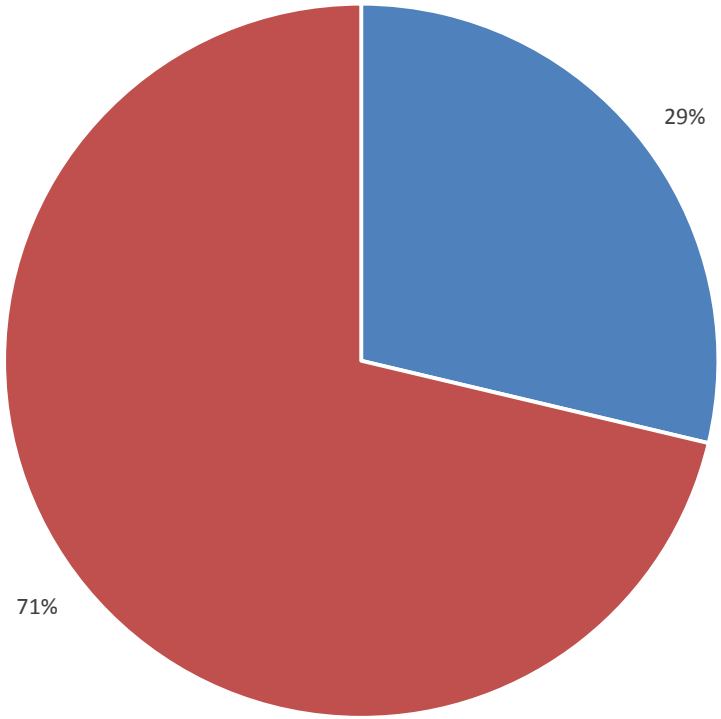
- Approximately 87% of individuals served through Medicaid are enrolled in Managed Care
- Primary populations not included: enrollees on the Passport, Assisted Living, Individual Options, Level One and SELF Waivers - along with most nursing facility residents
- Medicaid – and now Managed Care cover the entire spectrum of health care needs: Primary/Acute Care, Pharmacy, Behavioral Health and long-term care services
- Including federal dollars, the Ohio Medicaid Budget is over $27 Billion dollars – it is the single largest insurance company in the state

Medicaid / Long-term care penetration

LTC Expenditures FY17
LTC = $7.3 Billion



Long Term Care Expenditures SFY17
All Medicaid = $25.6 Billion



Background Information

- Re-procure Managed Care Contracts as needed, typically every 5 years.
- Managed Care Provider Agreement stipulates ODM sanction authority over the Plans to ensure performance (withholds, fines, points, enrollment suspension)
- Performance Standards: HEDIS Measures, Withhold Program, Operational Compliance Standards
- Automated Health Systems (AHS) is Ohio Medicaid's "enrollment broker" and vendor for the Medicaid Consumer Hotline.

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

The latest on MLTSS

MLTSS: High level overview

- Would impact approximately 100,000 individuals
- Would procure 3 MCP's for the program
- Would be a separate line of business – but streamlined to work collaboratively with My Care Ohio
- Commitment to reduce administrative complexities as experienced with MyCare
- The Department is committed to working through a collaborative and a flexible approach to system challenges and solutions with stakeholder engagement
- Many design decisions were made during the budget process to create a successful program

Patient-Centered Medicaid Managed Care Long-Term Services and Support Study Committee

- Established by Am Sub HB 49
- The Study Committee shall examine the merits of including home and community-based services and nursing facility services under managed care
- The committee is composed of legislators, agency directors and stakeholder groups.
- Report of the committee is due to the General Assembly by December 31, 2018.

Possible Committee Topics

- Benefits to Managed Care
  - » Care coordination
  - » Improved health outcomes
- MyCare – Successes and challenges
- Efficient Implementation/transition to a new program
- Program and rule redundancies in state's current LTSS system
- Rewards for providers meeting high quality standards, value based purchasing
- Cost of program to the state, Medicaid Managed Care plans, providers and recipients

In Summary

- ODM will continue to evaluate the merits of moving towards an MLTSS system in conjunction with the Study Committee
- Work will continue on refinement of design approaches with input from stakeholders
- Program merits and design report will be shared with the new Administration in 2019 for consideration
- Anticipating the first committee meeting will be in December

MLTSS Webpage/updates

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INITIATIVES > MLTSS

Managed Long-Term Services and Supports

In the latest biennial budget, the Ohio General Assembly created the Patient-Centered Medicaid Managed Care Long-Term Services and Supports Study Committee to examine the merits of integrating the home and community based services (HCBS) program and nursing facility services into Medicaid managed care. The legislative committee was created in response to the Administration's stated goal of moving to Managed Long-Term Services and Supports (MLTSS) before the end of biennium.

In deference to the General Assembly's desire to have a joint legislative committee study the benefits of MLTSS, and to allow sufficient time for an effective implementation, the Ohio Department of Medicaid (ODM) will take no immediate action to implement an MLTSS program. Instead, ODM will use the opportunity to work with the Committee, Medicaid managed care plans, HCBS and nursing facility provider associations, and other interested stakeholders to develop an effective MLTSS model for consideration by the next Administration.

Latest Updates:

ODM Letter to Ohio General Assembly, 08/21/17
MyCare Ohio Progress Report, 04/25/17
Ohio Long-Term Care Consumer Guide
Demonstrating the Value of Medicaid MLTSS Programs

Additional Resources:

PLEASE NOTE: These documents were originally made available during State Budget 2018-2019 discussions. ODM is no longer taking immediate action to implement an MLTSS program, so these documents are no longer applicable. These documents are posted for usage by the Patient-Centered Medicaid Managed Care Long-Term Services and Supports Study Committee.

Key MLTSS Design Features
Managed Long-Term Services and Supports FAQ
Managed Long Services and Supports Stakeholder Meeting Presentation, 05/30/17
Managed Long-Term Services and Supports Stakeholder Meeting Presentation, 03/31/17
Ohio MLTSS Draft Implementation Timeline

Initial Design Decisions

(as formulated during budget development)

Why MLTSS ?

- Promote the health, safety, and well-being– through care coordination.
- Expand community LTSS options, and streamline and standardize the way people access them.
- Create a system where health care providers are incentivized to keep individuals healthy and eliminate gaps in service delivery.
- Strengthen the focus on quality measurement, including both quality of life and quality of care, in order to achieve better outcomes.
- Ensure transparency, accountability, effectiveness, and efficiency of the program.
- Ensure long-term sustainability of the system as demand for LTSS grows by managing costs. (Ohio Medicaid LTSS expenditures are growing at a faster than the national average)

MLTSS Decisions
Payment Innovation

- ODM Intends to reward higher performing providers and set standards around value based purchasing
- ODM will require plans to enter into a specific percentage of value based provider contracts with nursing facilities and other providers. These contracts will have a shared savings component
- ODM will develop state report cards, including nursing facilities, that will leverage existing data. These report cares will be used to identity high performing providers
- Plans will be required to reimburse top performing nursing facilities at a level greater than the base rate. Poor performing nursing facilities will not be eligible to receive the base rate
- After transition period, plans will not be required to contract with the worst performing NF's; member protections will be established through a collaborative process

MLTSS Design
Provider Reimbursement & Contracting

- ODM will implement prompt payment standards and penalties by provider type
- Provider access requirements will be tightened to ensure participation of small or independent LTSS providers
- There will be a 180 day minimum timeframe for claims submission
- The state will commit to enhance the state complaint system for provider assistance
- There will be a Transition of Care requirements of 365 days for Nursing facilities
- Simplified approach to provider credentialing to reduce wait time

MLTSS Decisions
Care Coordination

- ODM will require the plans to contract with the AAA's for waiver service coordination with the option of full care coordination
- ODM will standardize a comprehensive waiver assessment to be applied across the full spectrum of venues of LTSS programming
- Plan care coordination requirements (for individuals in nursing facilities) will be adjusted based on the nursing facility rating
- Permissive language will allow creativity between the MCP's and providers of care coordination. It will include the option for incentivized PMPM arrangements

MyCare Ohio

MyCare Ohio

- Three year demonstration project that integrates Medicare and Medicaid into one program operated by a Medicare Medicaid Plan (MMP)
- Current enrollment is at its highest: Approximately 112,000
- ODM 3 year report on website
- Plan to ask CMS for additional flexibility
- The future of My Care Ohio… (expires 12/31/2019)

MyCare Ohio: 2 Recent PA Changes:

Transportation: Managed care plans should *contract with transportation providers experienced in providing transportation to individuals with LTSS needs*. Experience should include:

- ability to help the member transfer between the pick-up location and the vehicle, to enter and exit the vehicle;
- sensitivity to aging adults living with disabilities;
- the capacity to meet individual member needs when transporting.
- We continue to explore how we can improve transportation services, including requiring our plans to use a standardized form for transportation services.

Accuracy of payments:

- ODM pulled out *NF payments as a separate prompt pay standard* subject to compliance actions. Plans are required to pay 90% of all submitted clean claims within 30 days of the date of receipt and 99% of such claims within 90 days of the date of receipt
  - Plans are required to load rates within 30 calendar days of being notified by ODM and must give a 30-calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payments processing.

  - Plans' provider portals must allow for the availability of all remittance advices upon request, and capable of elements such as the following submission, resubmission and adjustment of claims.

Recent Quality Improvement Program Changes

- Better align with the Medicaid Quality Strategy.
- Introduce population health approach to MyCare Ohio Program:
  - » Data are used to risk stratify members and group into population streams: healthy adults, chronic conditions, and behavioral health.
  - » Comprehensive offering of services tailored to population stream and risk level – e.g., health and wellness programs, disease management, care management
- Extend greater flexibility to the MCPs with the design and implementation of care management programs to achieve improved outcomes
  - » Revise requirements that were overly prescriptive or not value-added

Ohio Medicaid's Transformational Quality Strategy

Making Ohio Better by improving the health of Ohioans.

Focus Populations	Design & Implement "Pay for Value"	Desired Health Improvements: Health Equity
Healthy Children & Adults	Episodes of Care; Patient - Centered Medical Homes; Social Determinants of Health; Community Engagement; Actionable Data	Preventative Screenings
Women of Reproductive Age (14 to 45)		Improved pre-term birth & infant mortality rates
Behavioral Health		Integrated Behavioral & Physical Health Care; Appropriate Prescribing
Chronic Conditions		Well Managed Asthma, Diabetes & Hypertension

SPECIAL INITIATIVES Behavioral Health Redesign & Infant Mortality Reduction

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Provider Complaints

- After the provider has tried to work with the MCP without results, a provider complaint can be submitted to **MCP.ohio.gov**
- Open the link and scroll down to:

Providers → Managed Care → For Providers → Complaint form

- Complaints regarding access will be responded to in 2 days; all others will be responded to within 15 business days.

MyCare Ohio

- Other areas currently in process:

- Quarterly HSAG reviews
- Adding VBR requirements for long-term care
- Patient Liability Project
- Level of Care: *How do we streamline managed care / fee for service*
- Ombudsman Grant: *increase nursing home residents' knowledge about MyCare Ohio and their coverage options (opt in/out)*

Other Current Initiatives

Other Medicaid Managed Care Initiatives

- Budget
- Behavioral Health Redesign in My Care Jan, 2018
- Full Behavioral Health Carve in July 2018
- Quality Withhold Program enhancements
- Revised Managed Care Access Standards
- Expanding Value Based Reimbursement
- NF Exception Reviews
- DME Rule/ Plan Guidelines
- Pharmacy standards (Single PDL)

Questions