JMOC Update

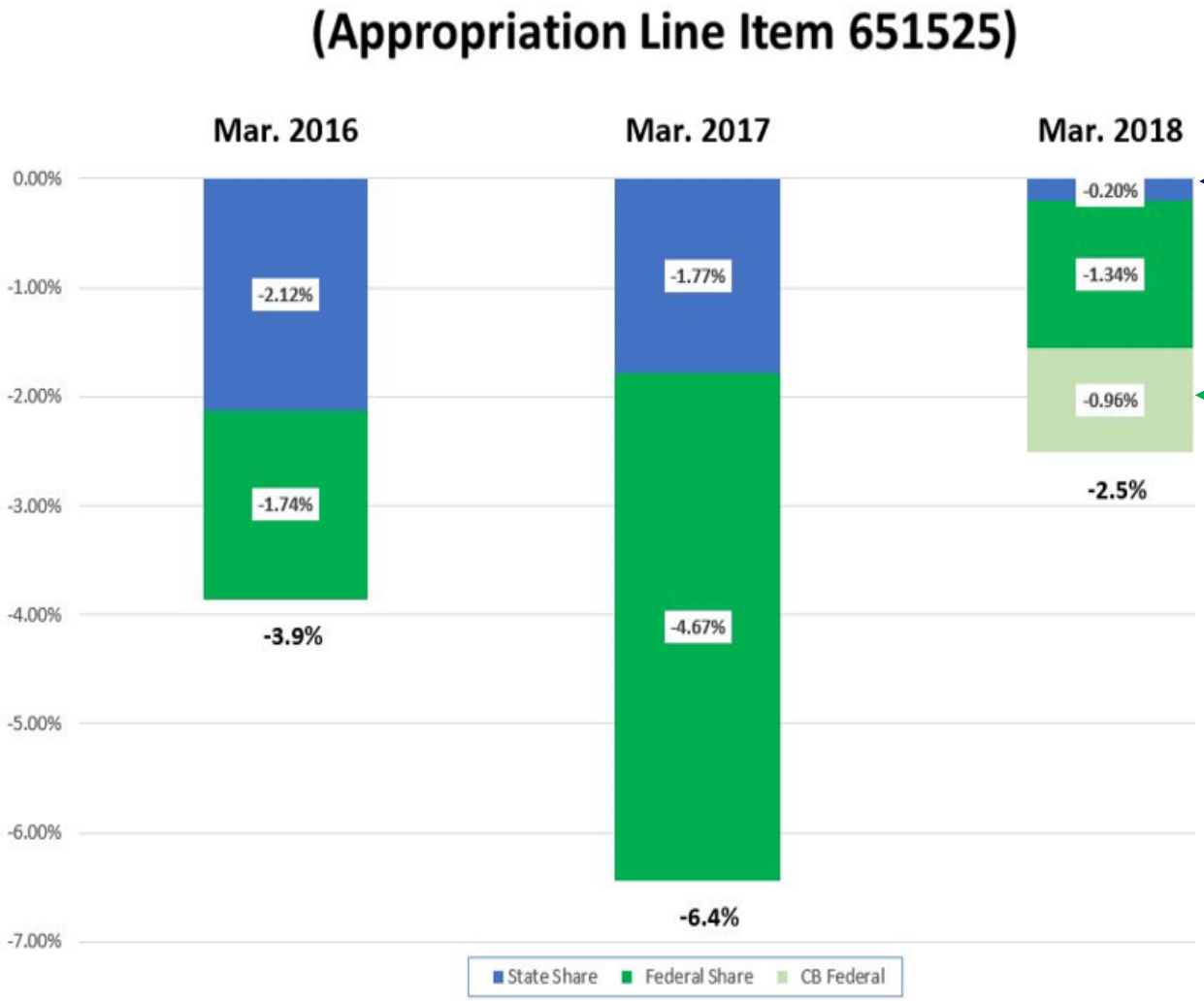
Barbara R. Sears, Director
Tracy Plouck, Director
April 19, 2018

Ohio | Department of Medicaid
Department of Mental Health and Addiction Services

TODAY'S AGENDA

- **Ohio Medicaid Budget Update**
- Electronic Visit Verification
- Behavioral Health Redesign
- Discussion

Ohio Medicaid Budget Variance



Only a small part of the variance in 651525 is state share that can be used to fund provider payments

Most of the variance is related to the one-time Federal Share spending authority change of $98 million in November 2017.

Medicaid Budget Activities in May …

- Medicaid budget reprojection
- Hospital recalibration (underway)
- Hospital FY19 5% rate reduction (if needed)
- Prepare FY19 Controlling Board release of funds
  - »$311 Million

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Electronic Visit Verification (EVV)

- The Centers for Medicare and Medicaid Services (CMS) established requirements for all states to use an EVV system, in accordance with the 21st Century CURES Act.
- EVV System means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to:
  - The type of service performed;
  - The individual receiving the service;
  - The date of the service;
  - The location of service delivery;
  - The individual providing the service; and
  - The time the service begins and ends.
- Recording this information is already required by program rules—EVV implementation did not create them.

EVV Benefits

- EVV is a tool for electronically capturing point-of-service information for certain home and community-based services.
  - Near real-time processing capability
  - GPS-based system with telephony and manual visit entry as alternative data collection methods
- Promotes quality of care
  - Enhanced care coordination and data sharing
- Promotes program integrity
  - Reduce billing errors and improve payment accuracy
  - Verifies that a caregiver is physically present for a visit

EVV Phase 1: January-Summer 2018

- Ohio Home Care Waiver Services
- "Soft" roll out—claims are not being denied based on EVV information
- This summer, we will begin to use visit information in claims adjudication
- In response to stakeholder participation, our vendor has developed an application that can be used on a personal mobile device owned by the provider or direct care worker

EVV Phase 2: Scheduled to Begin Fall 2018

- One EVV system across Medicaid funded services
  - Waivers administered by our partner state agencies (PASSPORT, Level One, Individual Options and SELF)
  - Managed Care (traditional and MyCare Ohio)
- Current work includes design, outreach and training, and collaboration with:
  - Stakeholders (individuals, families, and other organizations)
  - Partner agencies (Aging and DODD)
  - Managed Care Plans (have been involved since the beginning of development of phase 1)

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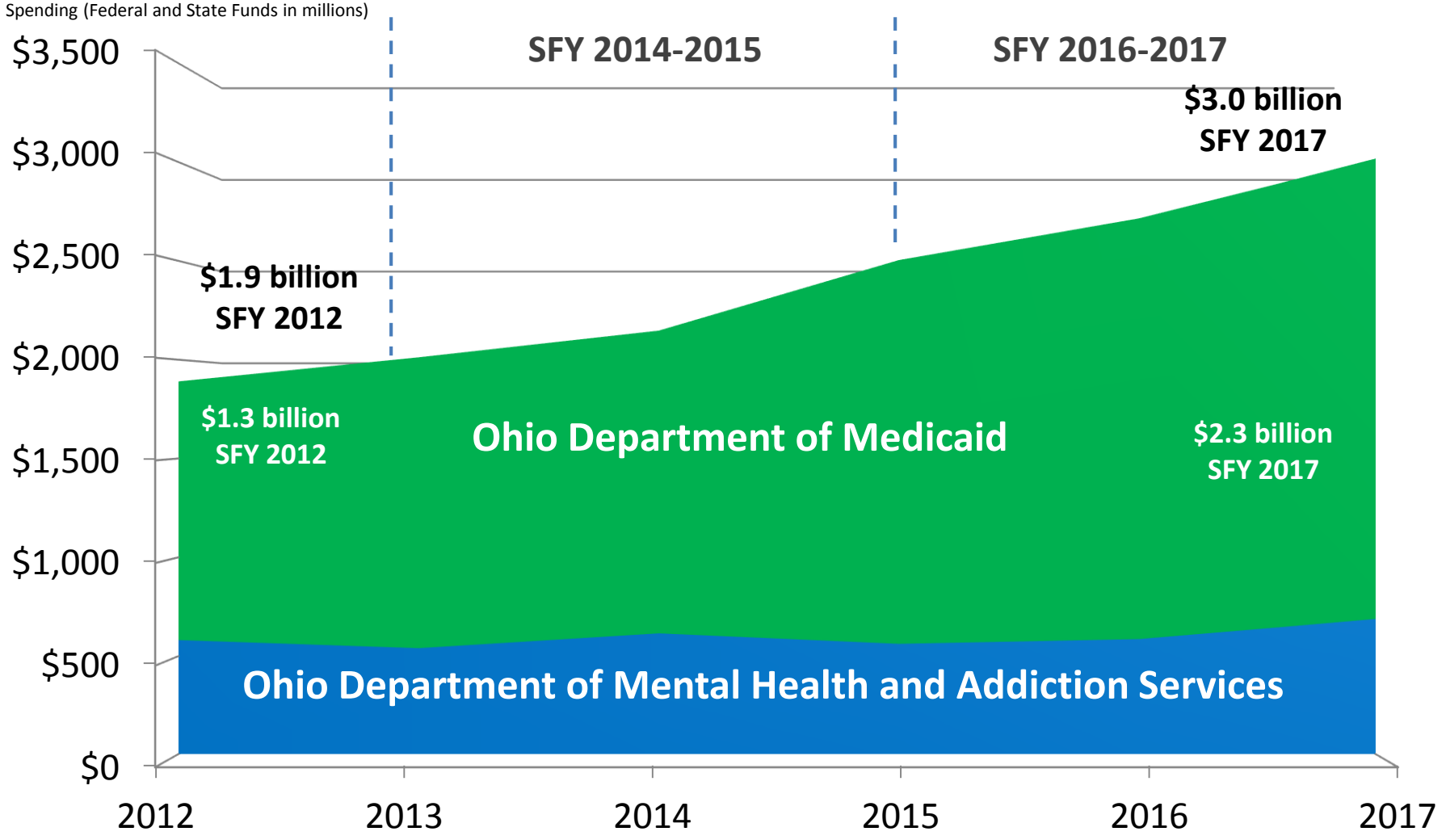
Behavioral Health Redesign Strategic Plan

1. **Elevation (2012)** – shift Medicaid match to the state to ensure more consistent provision of treatment services statewide, supported by Departments of Medicaid and Mental Health and Addiction Services
2. **Expansion (2014)** – extended Medicaid coverage to more than 630,000 very low-income Ohioans with behavioral health needs who previously relied on county-funded services or went untreated

Ohio's Behavioral Health System Capacity

Total MHAS and Medicaid Behavioral Health Spending (Federal and State Funds in millions)



Source: Ohio Departments of Medicaid and Mental Health and Addiction Services (January 2017).

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3. **Modernization (January 1, 2018)** – expand Medicaid services for individuals with the most intense need and update Medicaid billing codes for behavioral health providers to align with national standards

Current Challenges	Redesign Solutions
• Provider-centered care	• Patient-centered care
• Antiquated billing codes	• National coding standards
• Insufficient code set (17 codes)	• Transparency (120 codes)
• Rates not tied to provider type	• Rates reflect qualifications
• Different rates for MH and SUD	• One fee schedule for MH and SUD
• Rendering practitioner is unknown	• Rendering practitioner is clear
• Limited rehabilitation options	• Array of rehabilitation options
• Limited access to community behavioral health services	• Extensive network also including hospitals and primary care
• Multiple, separate providers	• Collaboration among providers
• Intense needs not coordinated	• Coordinate most intensive needs

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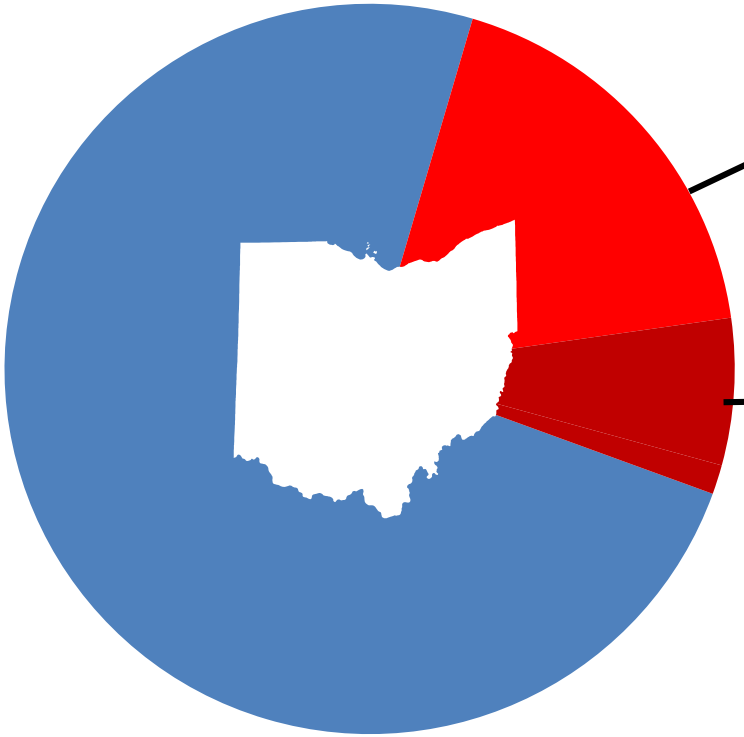
3. **Modernization (January 1, 2018)** – expand Medicaid services for individuals with the most intense need and update Medicaid billing codes for behavioral health providers to align with national standards
4. **Integration (July 1, 2018)** – coordinate physical and behavioral health care services within Medicaid managed care to support recovery for individuals with a substance use disorder or mental illness

Who benefits from integrated physical/BH services?

Approximately 26 percent of the total Medicaid population (in red) has been diagnosed with and treated for a behavioral health condition



70% of members with BH needs currently are managed through primary care

30% of members with BH needs currently receive more intensive support or are eligible for additional services under BH redesign

100% of members with BH needs will benefit from additional care coordination through Medicaid managed care beginning July 1, 2018

Why Medicaid Managed Care?

- **Improved health outcomes by paying for quality:** ability to incentivize/penalize performance for member outcomes and experience
- **Access to care:** federally-mandated provider network requirements and monitoring across all provider types
- **Value-based reimbursement:** allows for a system to reward plans and providers based on performance and the quality of services provided
- **Care Management:** allows for person-centered care integration based on the needs of the whole person
- **Long-term sustainability:** better able to predict budget due to full-risk managed care contracts

Comprehensive Benefit Package

Ohio's Medicaid managed care program covers all federally-mandated services plus optional services Ohio chooses 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
- Nurse mid-wife
- Prescription drugs
- Ambulance or medical transportation
- Dental services
- Behavioral Health services (e.g., ACT, IHBT, SUD Residential, OTPs)

Flexibility to Provide Additional Benefits

Medicaid managed care offers an expanded service package for members with an enhanced focus on improving health outcomes

- Enhanced Care Management
- Integration of Care
- Single Point of Accountability
- Respite Services (adults & children)
- Network Standards & Online Directory
- Quality Performance Program
- Grievance resolution system
- Toll-free member services hotline
- Additional transportation, smoking cessation, OTC cards
- Participation incentives
- Extended office hours (varies among plans)
- Health Education Materials and preventative care reminders

Routine Quality Measurement

Current Behavioral Health	Measure Set	Medicaid Managed Care Provider Agreement
Tobacco Use Screening and Cessation	AMA-PCPI	Y
Follow-up After Mental Health Hospitalization – within 7 days	HEDIS	Y
Follow-up After ED Visit for AOD – within 7 days	HEDIS	Y
Follow-up After ED Visit for Mental Illness – within 7 days	HEDIS	Y
Antidepressant Medication Management – Effective Acute Phase Treatment	HEDIS	Y
Antidepressant Medication Management – Effective Continuation	HEDIS	Y
Initiation of Alcohol and Other Drug Dependence Treatment	HEDIS	Y
Engagement of Alcohol and Other Drug Dependence Treatment	HEDIS	Y
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	HEDIS	Y
Follow-up for Children Prescribed ADHD Medication, Initiation and Continuation & Management	HEDIS	Y

Current Efficiency	Measure Set	Medicaid Managed Care Provider Agreement
ED Visits/1,000 member months	HEDIS	Y
Behavioral health-related inpatient admissions/1,000 member months	HEDIS	Y

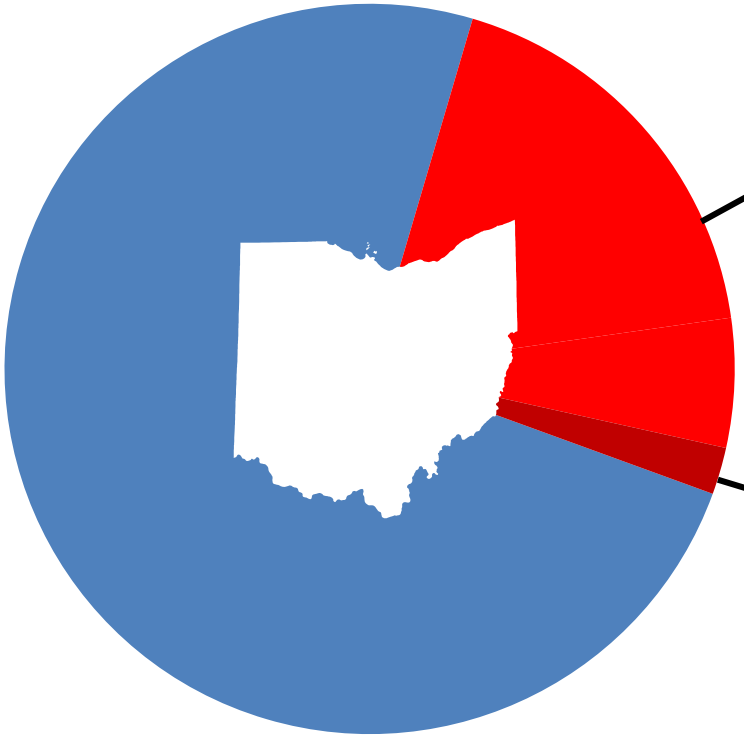
*Subset of existing measures in managed care provider agreement

Reliable Care Management

- Members can access care management services when needed.
- Managed care plans are responsible for providing comprehensive, integrated care management services and partnering with other entities to ensure no duplication or gaps in services.
- Approach to care management must:
  - be person and family centered;
  - be supportive of the provider-patient relationship;
  - comprehensively consider physical, behavioral, social, and safety needs;
  - emphasize cross continuum and system collaboration; and
  - promote self-care, independence, and optimal health and wellness.
- Specific focus on special populations – e.g., children with special health care needs, justice-involved

How will care coordination improve after July 1?

Approximately 26 percent of the total Medicaid population (in red) has been diagnosed with and treated for a behavioral health condition

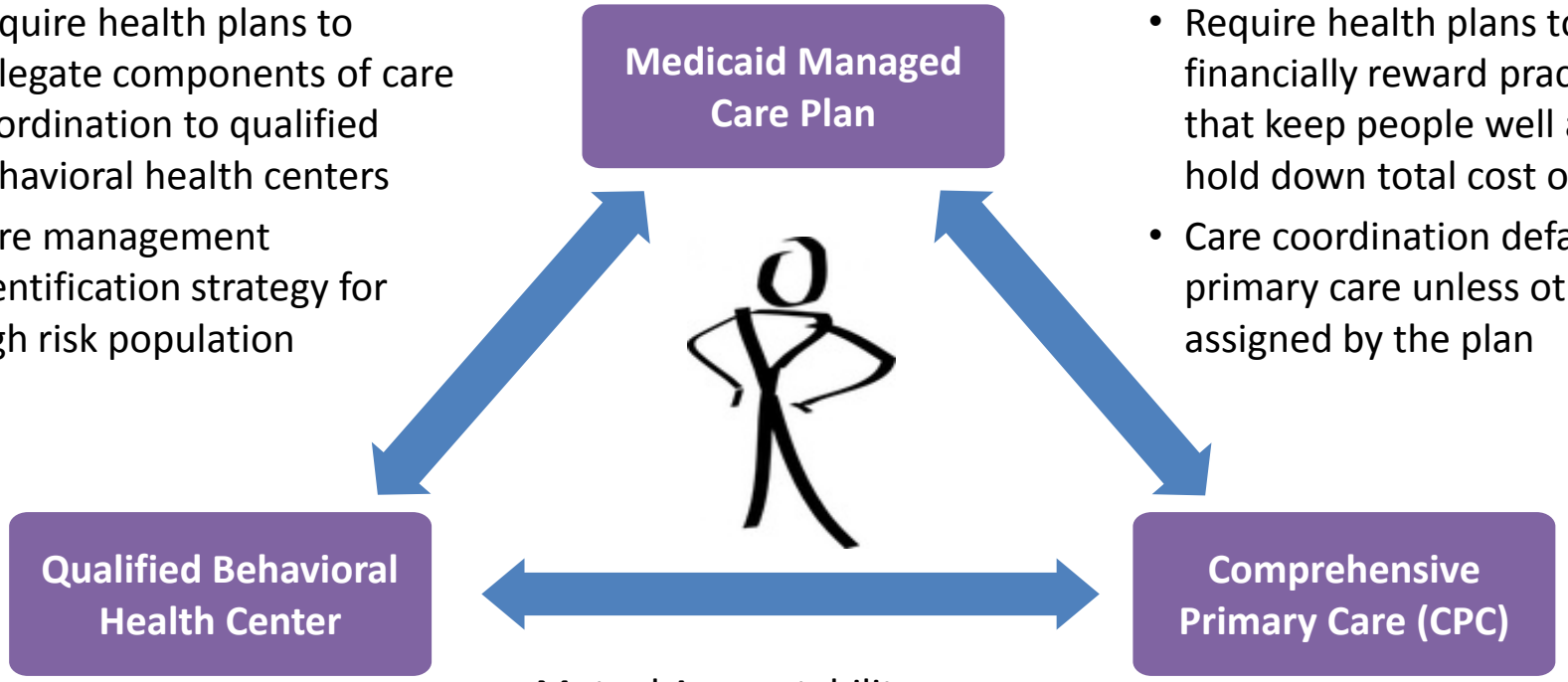


90-95% of members with BH needs will receive care coordination through the existing five Medicaid managed care plans

5-10% of members with the most intensive BH needs will receive care coordination from a Behavioral Health Center that is specifically qualified to integrate and manage physical and BH services

A preview of the intensive care coordination model …

- Require health plans to delegate components of care coordination to qualified behavioral health centers
- Care management identification strategy for high risk population



- Require health plans to financially reward practices that keep people well and hold down total cost of care
- Care coordination defaults to primary care unless otherwise assigned by the plan

- Mutual Accountability
- Alignment on care plan, member relationship, transitions of care, etc.
- Common identification of needs and assignment of care coordination

A preview of future agendas for JMOC …

- BH Care Coordination
  - » Stakeholder Process
  - » Implementation Timeline
  - » Key Design Elements
    - – Target Population
    - – Provider Eligibility
    - – Attribution
    - – Care Coordination Activities
    - – Quality and Efficiency Measures
    - – Reporting
    - – Payment Structure and Financing

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