JMOC Update

Barbara R. Sears, Director

September 20, 2018

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

Today's Agenda

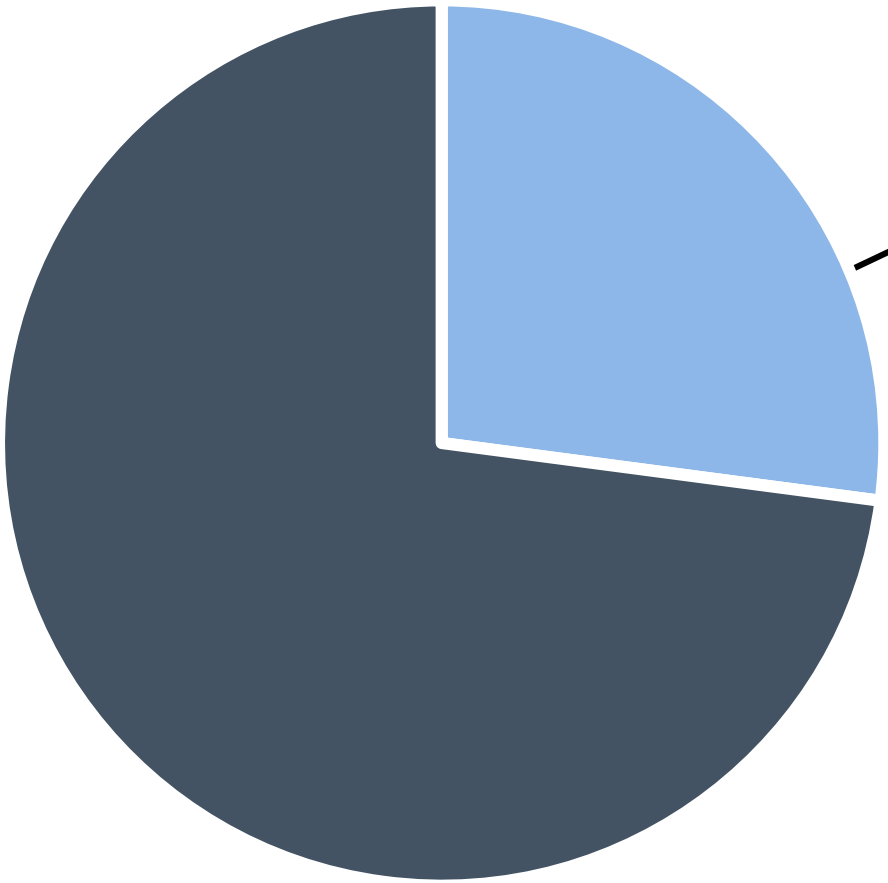
- **Ohio Medicaid Budget Update**
- **Behavioral Health Integration Purpose and Review**
- Behavioral Health Integration Status Updates

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
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

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

Individuals Receiving Behavioral Health Services



26% of the total Medicaid population have been diagnosed with and treated for a behavioral health condition

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

Safeguards Post Implementation

- Safeguards effective July 1 for both the members receiving behavioral health services and for the providers delivering those services.
- Members can continue to use any provider until at least **December 31, 2018**
- MCPs will pay **ANY** service provider for their members for this time period.
  - » After this six month period, single case agreements are always available.
  - » This time frame was *extended to include an open enrollment* period where members may change plans if desired.

Safeguards Post Implementation

Member/Provider Safeguards:

- MCPs will follow the Medicaid Fee For Service (FFS) behavioral health coverage policies through **June 30, 2019**
- MCPs will honor prior authorizations approved by Medicaid FFS prior to July 1, 2018 until the PA expires
- MCPs shall maintain Medicaid FFS payment rates as a floor for behavioral health services through **June 30, 2019** unless the plans and providers agree otherwise
- The MCP shall accept claims for BH services for at least 180 calendar days after service date (and in most cases, 365 days)

Prior Authorization

- Less than 2% of behavioral health services require a Prior Authorization to access services
- Assertive community treatment (ACT), intensive home based treatment (IHBT) and substance use disorder (SUD) residential treatment will be prior authorized as expeditiously as the member's health condition requires and within 48 hours

Safeguards Post Implementation

- Ohio Medicaid is also committed to a **Managed Care Contingency Plan** for interested providers similar in nature to what was established in Fee For Service in January
- The plans have made contingency payments for July, August and September totaling **$110,259,203.47**
- Final contingency payment will be made in October

Today's Agenda

- Ohio Medicaid Budget Update
- Behavioral Health Integration Purpose and Review
- **Behavioral Health Integration Status Updates**

Working Together Post Implementation – BH Task Force

- Convenes weekly to discuss post implementation progress
- Includes provider and advocacy groups, MCP, as well as ODM, MHAS and JMOC
- Working together through issues
- Typical Agenda includes:
  - » Configuration Issues & Updates
  - » Practitioner Enrollment Updates
  - » MCP Report Out
  - » Glide Path Report Updates
  - » Contingency Plan Updates
  - » MCP Rapid Response Team Report-Out

Patients Access to Care Remains Strong - Network Adequacy Standard Progress

MCP	Aug 13th – C&C				Aug 27th – C&C				Sep 10th – C&C			
	# of counties meeting network standard		% of counties meeting network standard*		# of counties meeting network standard		% of counties meeting network standard*		# of counties meeting network standard		% of counties meeting network standard*	
	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD	MH	SUD
Buckeye Health Plan	86	80	98%	91%	86	81	98%	92%	86	81	98%	92%
CareSource	87	88	99%	100%	88	88	100%	100%	88	88	100%	100%
Molina	88	88	100%	100%	88	88	100%	100%	88	88	100%	100%
Paramount	86	86	98%	98%	86	86	98%	98%	86	86	98%	98%
United Healthcare	88	87	100%	99%	88	87	100%	99%	88	88	100%	100%

**As a percentage of all 88 Ohio counties*

Prior Authorization are not a Barrier to Access – July 2018

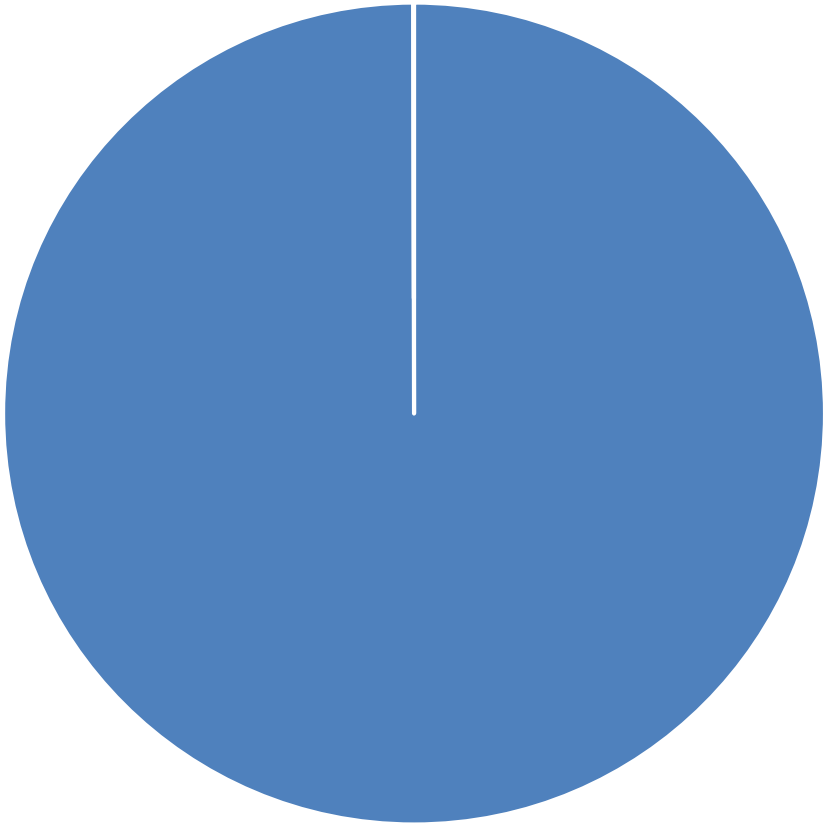
MCP	Total # req.	# approved	% approved	# denied	% denied
Buckeye	274	274	100%	0	0%
CareSource	353	321	91%	32	9%
Molina	241	234	97%	7	3%
Paramount	233	233	100%	0	0%
United	307	305	99%	2	1%
Total	**1408**	**1367**	**97%**	**41**	**3%**

**Assertive community treatment (ACT), intensive home based treatment (IHBT) and substance use disorder (SUD) residential treatment/partial hospitalization and assessments and screening

Member Complaints and Grievances Filed

July 1 – August 31, 2018

The MCPs and ODM received a total of 36 BH related complaints and grievances between July 1, 2018 and August 31, 2018.



Types of Complaints/Grievances

- Care Management
- Transportation
- Billing
- Dissatisfaction with Provider
- Panel/Non-Panel Access

BH Redesign compared to BH Integration

Summary Data						
Phase	**Contingency Payment Agreements - Provider Level**	**Cum. Providers through W8**	**Cum. (Paid/Denied) Line Items through W8**	**Cum. Billing Payments through W8**	**Contingency Payments (1st Installment for 2-month Period)**	**Total Payments through W8**
BH Redesign:	72	470	1,533,616	$70,264,574	$14,881,596	$85,146,170
BH Integration:	245	535	1,103,128	$73,282,402	$73,103,367	$146,385,768
Result:	**173**	**65**	**-430,488**	**$3,017,828**	**$58,221,770**	**$61,239,598**

- Week-over-week comparison of activity through the first 8 weeks (W8) of BH Redesign compared to BH Integration. It does not include claims run-out and is another way we are tracking progress
- An updated version, including the week-by-week comparison, will be shared with the BH Task Force at the end of the month

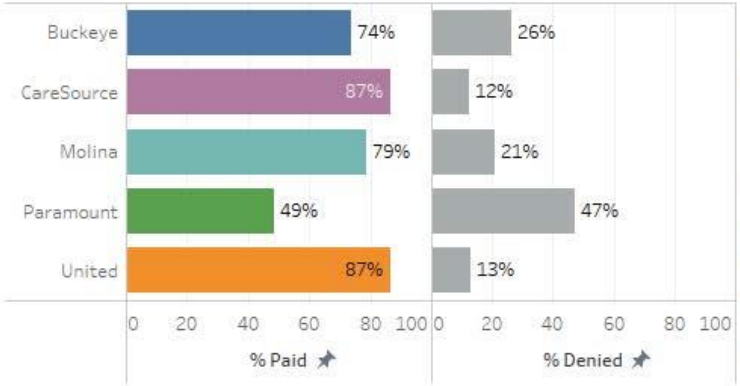
Behavioral Health July Glide Path - Plan Category Breakdown

	Unique Providers That Have Submitted Claims	Total Clean Claims Paid	Total Clean Claims Denied	Pended Claims	Total Claims	Total Paid Amount ($)	Unclean Claims
Buckeye	259	30,473	10,909	21	41,403	2,610,153	
CareSource	329	147,868	21,110	1,263	170,241	13,923,084	2,926
Molina	191	24,659	6,507	106	31,272	2,417,303	2,746
Paramount	91	17,456	16,963	1,398	35,817	1,740,982	2,984
United	213	27,918	4,228		32,146	2,759,973	5,843
Grand Total		248,374	59,717	2,788	310,879	23,451,494	14,499

Data timeframe is 7-1-18 thru 7-31-18 as reported on 8-31-18

On average, plans denied 19% of claims received in July

% Paid or Denied - July



% Paid or Denied is for the entire month of July. Total may not add up to 100% due to pended claims.

Contingency Payments - July/August

Plan	Number of Unduplicated Providers Sent a Contingency Payment	Total Amount of Contingency Payments - July and August Combine
Buckeye	146	$7,432,105.06
CareSource	245	$44,580,014.63
Molina	139	$8,215,713.00
Paramount	144	$6,346,428.10
United	147	$6,529,106.54

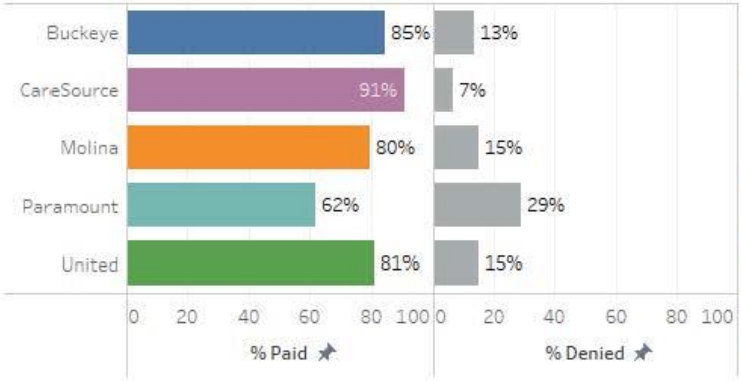
Behavioral Health August Glide Path - Plan Category Breakdown

	Unique Providers That Have Submitted Claims	Total Clean Claims Paid	Total Clean Claims Denied	Pended Claims	Total Claims	Total Paid Amount ($)	Unclean Claims
Buckeye	353	75,834	12,030	1,840	89,704	6,863,163	
CareSource	473	353,354	25,417	9,411	388,182	33,939,422	12,440
Molina	358	71,292	13,511	4,380	89,183	6,980,940	5,868
Paramount	213	48,316	22,707	7,204	78,227	4,336,167	6,924
United	284	69,403	12,917	3,036	85,356	7,040,366	9,215
Grand Total		618,199	86,582	25,871	730,652	59,160,057	34,447

Data timeframe is 8-1-18 thru 8-31-18 as reported on 9-14-18

On average, plans denied 16% of claims received in August

% Paid or Denied - August



% Paid or Denied is for the entire month of August. Total may not add up to 100% due to pended claims.

Contingency Payments - September

Plan	Sum of Number of Unduplicated Providers Sent a Contingency Payment	Sum of Total Amount of Contingency Payments
Buckeye	144	$3,716,779.96
CareSource	241	$22,675,208.37
Molina	147	$4,143,491.94
Paramount	140	$3,170,432.07
United	152	$3,449,923.80

Providers Receiving Advanced Payment not Billing

Plan	Total Providers that were given advance payments	# of Providers not billing yet
Buckeye	196	47
CareSource	242	32
Molina	210	35
Paramount	196	102
United Healthcare	203	64

Note: Provider received advance payment from a particular plan but has not billed that plan yet

Top Claim Denial Reasons Across MCP

- Missing primary insurance information
- Invalid/missing modifier (service code or degree level modifier)
- Invalid diagnosis code for the service
- Procedure inappropriate for provider specialty (billing SUD services under MH NPI, practitioner credentials need updated, or billing lab codes without a contract)
- Member not enrolled with plan or no longer Medicaid eligible
- Invalid/missing NDC#
- Invalid/missing information from ordering physician

In summary

- Working collaboratively with providers and stakeholders
- All MCPs have rapid response teams in place and conduct regular meetings for providers
- Very few member have filed grievances and complaints
- Communication between MCP’s and Providers is key to resolving issues
- Provider Networks are in place and access to care remains strong
- Claim submissions and paid amounts to date in managed care are comparable to the same weeks post redesign in Fee For Service

In summary

- Prior authorization is not a barrier to access to care
- Contingency payments have helped mitigate risk – but also appears to have limited claim submissions
- Some providers are opting to discontinue advanced payment because they are successfully billing and getting paid
- While room for improvement exists, we are confident that BH integration is stable and improving month over month

When compared to the first two months of Redesign – more provider are billing managed care plans and more dollars are out the door!