Ohio Department of Medicaid

Agenda

1. Next Generation Program Updates
2. Ohio Medicaid Enterprise System Updates
3. Population Health: Alternative Payment Models
4. Population Health: OAK Learning Network
5. MyCare Ohio Updates
6. 1115 Reentry Waiver Opportunity Overview

Department of Medicaid

Next Generation Program

Jim Tassie

Deputy Director

Office of Managed Care & Project Management Office

Ohio Department of Medicaid

Ohio's Next Generation Medicaid Program

Mission Statement

Ohio Department of Medicaid

Next Generation of Ohio Medicaid

Improve design, delivery and timeliness of care coordination

Goals of Ohio's Future Managed Care Program

Department of Medicaid

Ohio Medicaid's Next Generation Managed Care Entities (MCEs)

OhioRISE

aetna

Aetna Better Health® of Ohio

Single Pharmacy Benefit Manager (SPBM)

gainwell

Gainwell Technologies

AmeriHealth Caritas

Care is the heart of our work

AmeriHealth Caritas Ohio, Inc.

Anthem

Anthem Blue Cross and Blue Shield

buckeye health plan

Buckeye Health Plan

CareSource

CareSource Ohio, Inc.

Humana

Humana Health Plan of Ohio, Inc.

MOLINA HEALTHCARE

Molina Healthcare of Ohio, Inc.

UnitedHealthcare Community Plan

United Healthcare Community Plan of Ohio, Inc.

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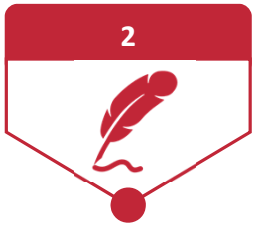
Next Generation Managed Care Plan Provider Impacts

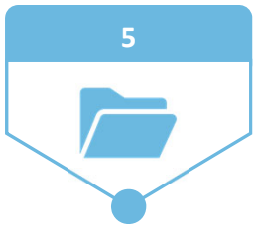
Next Generation Managed Care Plans
Seven Next Generation managed care organizations (MCO) began providing services to Ohio Medicaid members.



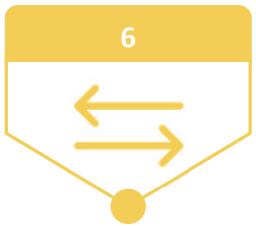
Managed Care Contracts
Contracts with the MCOs have been updated to ensure consistency and minimize differences between how providers interact with the Next Generation managed care plans.

Managed Care Plan Portal
Continue using managed care plan portals for direct data entry of claims submission and prior authorizations (PA). All managed care PAs are submitted directly to MCO.

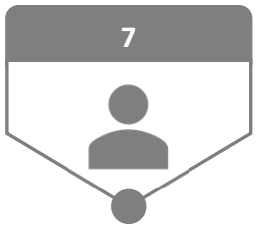
Member ID Number
For managed care claims submitted to a trading partner the Medicaid ID (or MMIS ID) must be the ID number used for claims processing. Providers can check member eligibility and member IDs via the Provider Network Management (PNM) module, which redirects to MITS.



External Medical Review
An external medical review is offered to providers who are unsatisfied with an MCO's, including the OhioRISE plan, decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.



Electronic Data Interchange (EDI)
Providers should confirm their trading partner is authorized to work with Deloitte, the new EDI vendor. EDI claims are submitted to the new EDI vendor. PAs will not be submitted to the new EDI.



Rendering Provider
EDI-submitted claims must only include one rendering provider.
Different rendering providers at the detail level are no longer acceptable.

**Exceptions for FFS Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers are detailed* https://medicaid.ohio.gov/static/About+Us/PoliciesGuidelines/MAL/MAL622-A.pdf

Next Generation Ohio Medicaid Implementation

Implementation Complete

July 1, 2022 **OhioRISE (Resilience though Integrated Systems)**	**OhioRISE** began providing specialized services that help children and youth with behavioral health needs and aid coordination of care for those who receive care across multiple systems.
October 1, 2022 **Centralized Credentialing** and **Single Pharmacy Benefit Manager (SPBM)**	**Centralized Provider Credentialing** began reducing the administrative burden on providers. Also, the **SPBM** began providing pharmacy services across all managed care plans and members.
February 1, 2023 **Next Generation Managed Care Plans**, **Electronic Data Interchange (EDI)**, and **Fiscal Intermediary (FI)**	**Next Generation managed care plans** were implemented, allowing members to experience benefits that help address their individual healthcare needs, such as increased access to care coordination and care management supports. The **EDI** became the new exchange point for trading partners on all claims-related activities, providing transparency and visibility regarding care and services. Additionally, the **FI** assists in routing managed care claims submitted to EDI and adjudicates and pays fee-for-service claims submitted to EDI.
June 30, 2024 **Provider Network Management (PNM) module,** and **FI** fee-for-service functionality	The **PNM module** system implementation streamlined direct data entered (DDE) fee-for-service claims and prior authorizations and other administrative tasks. The **FI** began adjudicating and paying FFS claims and facilitating FFS prior authorization processing.

Implementation Upcoming

At a later date **PNM** implementation complete	The **PNM module** implementation will be complete, streamlining managed care claims and prior authorizations for DDE submissions and other administrative tasks. The **FI** will assist in routing managed care claims and prior authorizations submitted through DDE.

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Ohio Medicaid Enterprise System

Dr. Matt Stearmer

Chief Data Officer

Ohio Department of Medicaid

OSMA Areas Of Concern - Resolved

Issues that are referenced on the CPSE report can be found on the ODM News for Providers public facing CPSE report. This link will take you to the Managed Care Ohio Medicaid site where you will click on get News, then News for Providers in the left-hand navigation and then select the CPSE report in the event you run into challenges with accessing the report directly through the link.

Title	Status	Description
General Reason Codes	Resolved	All appropriate CARC codes now have an associated RARC code. These additional codes along with improvements to the underlying adjudication logic should provide greater clarity on how to address claim denials. The IHD call centers are available to support provider interpretation of the codes as needed.
Claim Views	Resolved	ODM has located the source of the error. When duplicate control IDs are located within the same CLM01 field of the ST/SE for an EDI transaction the whole batch will fail. This has caused providers to need to manually enter these claims.
PNM Administrator	Resolved	This process remains, but it is part of the PNM design. The PNM team reports that this issues has died down significantly since Go-live. They have better training and IHD call center assistance, a simplified process, and more familiarity with the PNM system by the providers.

OSMA Areas Of Concern - Pending

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Title	Status	Description	CPSE ID
Crossover Claims	Pending – solution design in progress	ODM has located the source of the error. When duplicate control IDs are located within the same CLM01 field of the ST/SE for an EDI transaction the whole batch will fail. This has caused providers to need to manually enter these claims.	EDI Tab, Line 6
MCO Provider Data	Pending – in progress	Update on the PNM rollout and responsibility to keep the PNM up to date. One of the reasons we have not forced this through faster is because ODM has analyzed the potential negative impacts and the denial rate with full implementation would still be too high	NA
CLIA	Pending – in progress	The Fiscal Intermediary (FI) currently checks only the CLIA certification of the rendering provider. According to ODM policy, payment for a covered clinical laboratory procedure can be made if either the billing provider or the rendering provider has appropriate CLIA certification. The FI is developing code to check the billing provider first and then, if no appropriate certification is found, the rendering provider.	FI tab, Line 102
MCO Payment Processing Rules	Pending – in progress	Relative to FFS rules, Federal law permits plans to be able to implement their own adjudication rules different from FFS, however, ODM does review plan practices for administrative burden, and this is an area where additional guidance may be forthcoming. ODM will continue to actively enforce what has changed and what is allowed.	NA

OSMA Areas Of Concern - Pending

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Title	Status	Description	CPSE ID
General FFS Processing Claims	Pending	Please refer to CPSE	Lines: 52, 60, 61, 74, 75, 98, and 99
General MCO Eligibility Transaction Concerns	Pending	Please refer to CPSE	Lines: 64, 65, 66, 68, 69, and 118
Data Conversion/Rule Alignment Concerns	Pending	Please refer to CPSE	Lines: 78, 82, 85, 91, and 134
Medicare COBA claims	Pending	Please refer to CPSE	Lines: 125 and EDI 6

Payment and Denial Rate Analysis

- Overall, payments are on par with previous years
- Initial high denial rates and missing claims have been resolved for both FFS and Managed Care
- Initial denial rates are still higher than pre go-live rates.
  - Higher denial rates are due to a combination of system issues and the provider and trading partner learning curve with how to bill through the One Front Door.
- ODM will continue to monitor all systems and will continue to identify inefficiencies to reduce the overall administrative burden on providers so they can invest the additional time and resources into member care.

Managed Care: Average Payment Amount

Category	Ave Pre Go-Live	Post Go-Live
Managed Care Ave Monthly Payment	$ 114,255,234.73	$ 122,548,219.48

Fee For Service: Denial Rate and Payment Amount

Category	Pre Go-Live	Post Go-Live
Average Denial Rate	26.37%	32.33%
Average Monthly Payment	$14,228,645.84	$8,458,249.32
Total FFS Members	608k	483k

Top 10 Denial Reason Codes

Denial Reason	Count of Claims
MCO IS SOLELY RESPONSIBLE FOR SERVICE:	715719
Duplicate Claim Line (Mem/DOS/CPT(REV)/MOD)	431218
Duplicate Claim Line (Prov/Mem/DOS/CPT(REV)/MOD)	412801
DUPLICATE MEM/DOS/SERVICE CODE/PAY TO/MODIFIER	412063
Dup Mem/DOS/Service code/Pay To/Rendering Phys/Modifier	408193
NO ACTIVE PROVIDER CONTRACT	281984
DUPLICATE CLAIM (SAME PROVIDER/MEMBER/DOS)	259530
Invalid Medicare Action Code	225247
MEDICARE PROFESSIONAL XOVER PRICING RULES APPLIED	195504
Contract Term Restriction Group Validation Failed	180982

Ohio Department of Medicaid

Population Health: Alternative Payment Models

Dr. Mary Applegate
Medical Director

Ohio Department of Medicaid

Alternative Payment Model

Designed to encourage and finance transformation, fund new care and operations and reward value

Prioritize outcomes over process	• By funding population health activities, providers focus can be on meeting each patient's specific needs
Minimize provider burden	• No complicated billing system to master or additional data submission
Aligning care	• Create incentives to integrate care across systems and settings

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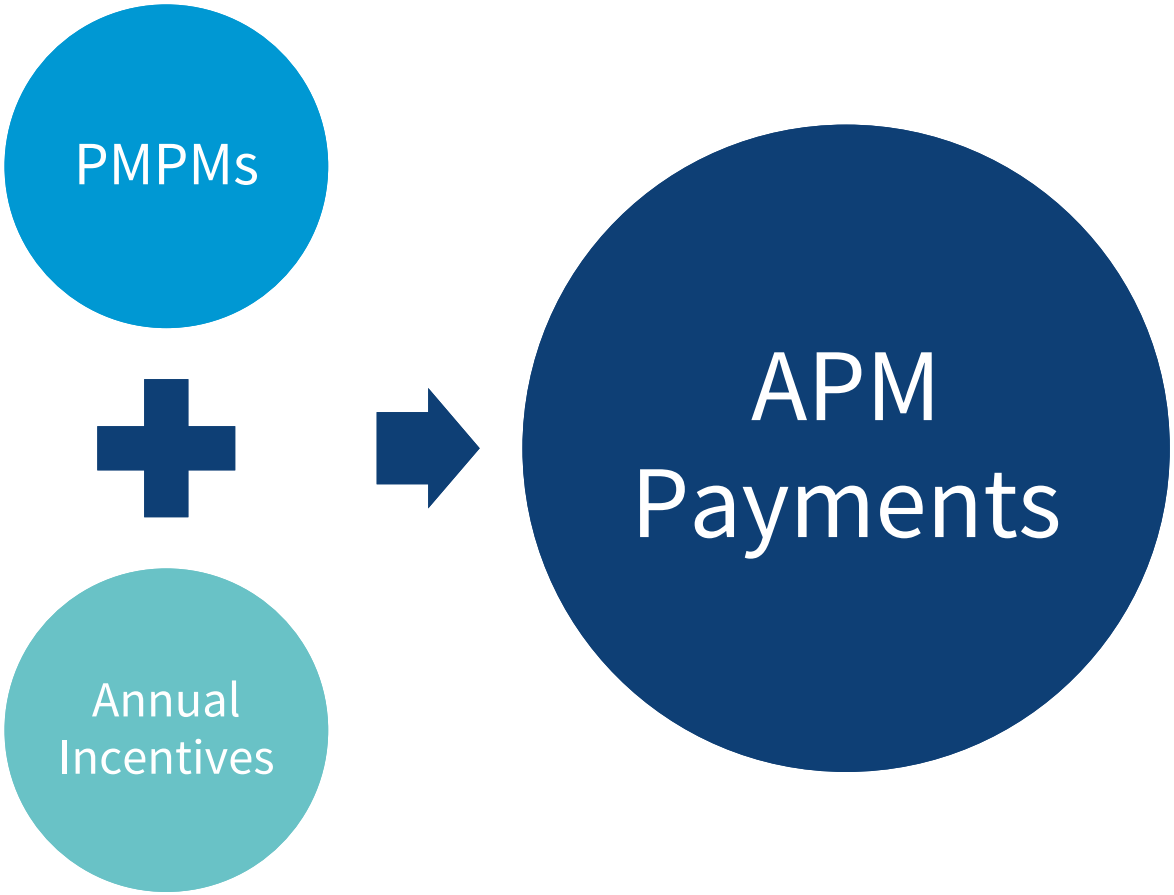
Components of ODM APMs

- 💰 Per member per month payments (paid quarterly, prospective)
- 💰 Bonus/incentive payments (paid annually, retrospective)



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ODM's Population Health Alternative Payment Models

Paying for value over volume

- Comprehensive Primary Care
  - Currently includes more than half of Medicaid population and spend
  - 19 quality metrics across four population health streams, including women's health, infant/child health, behavioral health, and chronic condition metrics
  - Includes a nested pediatric CPC for Kids model with additional payments for meeting child-specific quality goals

- Comprehensive Maternal Care
  - Currently includes ~40% of pregnant people with Medicaid coverage
  - 7 quality metrics focused on screenings and connections to care, including primary care

ODM's Population Health Alternative Payment Models

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Comprehensive Maternal Care

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ODM's Investments in Alternative Payment Models

Or, where's the money and why does it matter?

Clinicians can pivot from caring for patients only as individuals to a population health focus, improving the health of many patients systematically

CPC and CPC for Kids

- >$80M per year in prospective payments to practices
- Between $4M and $45M awarded per year in shared savings and bonus payments

CMC

~$4M per year in prospective payments to practices

Up to $2M per year in bonus payments

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Population Health: OAK Learning Network

Dr. Jon Barley, Ph.D.
Bureau of Health Research and
Quality Improvement Chief

Ohio Department of Medicaid

OAK

Outcomes Acceleration for Kids

A first-of-its-kind collaborative effort between Ohio families, Ohio Medicaid, Children's Hospitals, and Managed Care Entities.

Centered on Ohio's Families

OhioRISE | aetna

AmeriHealth Caritas Ohio

Anthem

buckeye health plan

CareSource

Humana Healthy Horizons in Ohio

MOLINA HEALTHCARE

United Healthcare Community Plan

University Hospitals Rainbow Babies & Children's
The Science of Health. The Art of Compassion

Akron Children's

PROMEDICA

dayton children's

Nationwide Children's
When your child needs a hospital, everything matters.

Cincinnati Children's

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AIM

To deliver the highest **quality care** to Ohio's pediatric Medicaid population and to achieve **superior outcomes**, ensure whole child health, and close **health equity** gaps.

Health Equity Focus

Transformational Change through Structured Quality Improvement (QI)

MCO Quality Withhold Project

Statewide Impact on All Ohio's Children

Ohio Department of Medicaid

OAK Regional Improvement Teams

Ohio Department of Medicaid

OAK Domains & Measures

Well Child:

Well Child Visits for Children

0-15 Months; 12-17 Years

Behavioral Health:

Follow-Up After ED Visit for Substance Use

7 day, Ages 13-17

Follow-Up After ED Visit for Mental Health

7 day, Ages 6-17

Asthma:

Asthma Medication Ratio

Ages 5-11; Ages 12-18

Sickle Cell:

Transcranial Ultrasound

2026 Goal: 10-15% Improvement!

Current Activities

Statewide workgroups are developing their *Theory of Improvement* for each domain using the structured Quality Improvement process

QI Tools:

- Voice of the Customer
- Process map(s)
- sFMEA(s)
- Root Cause Analysis
- Key Driver Diagram

Next Steps

Regional Improvement Teams

- Recruit practices in their regions
- Test interventions
- Report results

Statewide Domain Team

- Support regional improvement teams with interventions
- Analyze intervention results
- Select interventions to spread and sustain

Ohio Department of Medicaid

MyCare Ohio

Steven Alexander

Integrated Care Policy Section Chief

Ohio Department of Medicaid

MyCare Ohio overview

What is MyCare Ohio?

MyCare Ohio integrates Medicare and Medicaid benefits into one program, coordinated by a managed care plan.

One care coordinator

One care coordinator for both your Medicaid and Medicare benefits.

One organization

One organization responsible for both your Medicaid and Medicare benefits, allowing for more extensive service coverage.

Streamlined communication

You only receive communications from one organization, alleviating confusion.

Simple appeals

If you need to appeal a denial, you only need to contact one organization.

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MyCare Ohio care coordination

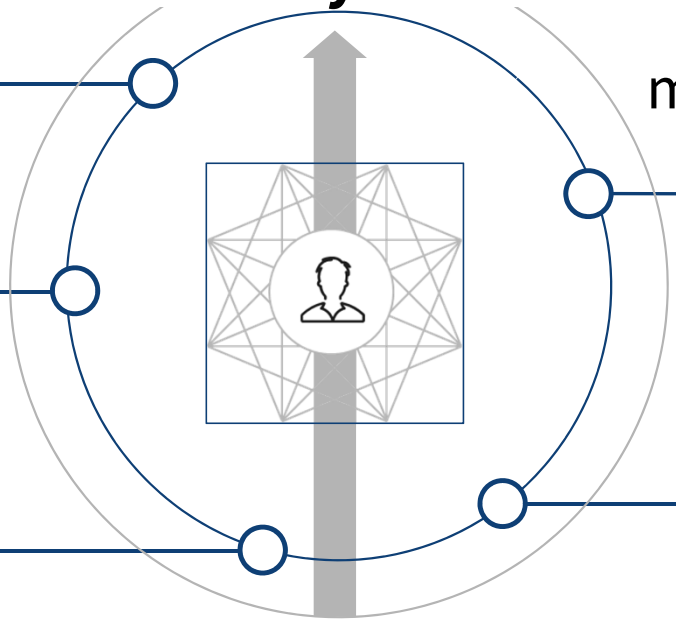
Each member enrolled in MyCare Ohio receives help coordinating their care. MyCare Ohio is the only way a member can receive care coordination across both Medicare and Medicaid.

Your care manager will assist you in:

Planning and scheduling your appointments.

Your understanding of your diagnosis and illness.

Connecting you to community resources to meet needs you may have.



Making sure you have the medication and supplies you need.

Understanding your healthcare benefits and what services are covered.

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MyCare Ohio benefits

There are many benefits to receiving Medicare and Medicaid through MyCare Ohio

Benefits of receiving dual benefits from a MyCare Ohio plan:

- Less likely to receive surprise bills from providers – more of your services are covered.
- You receive support to coordinate your care, so you are not stuck to figure out what services will be covered by Medicare or Medicaid.
- Impartial enrollment broker is available to help you find the plan that is best for you.
- Less time spent figuring out your healthcare services and appealing denials.

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What is the MyCare Ohio program trying to achieve?

MyCare Ohio program goals

Streamlined care

One point of contact for both Medicaid and Medicare services to streamline care.

Person-centered care

Person-centered care, seamless across services and care settings.

Service focus

Focus on wellness, prevention, and coordination of services.

Navigation

Easy for you and providers to navigate.

Consistency

Integrated care coordination and one benefit package.

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MyCare Ohio benefit package

What benefits are available through the MyCare Ohio plans?

All benefits available through the traditional Medicare and Medicaid programs, including long-term services and supports and behavioral health.

Additional “value-added” benefits, specific to each MyCare Ohio plan's healthcare package.

MyCare Ohio population eligibility

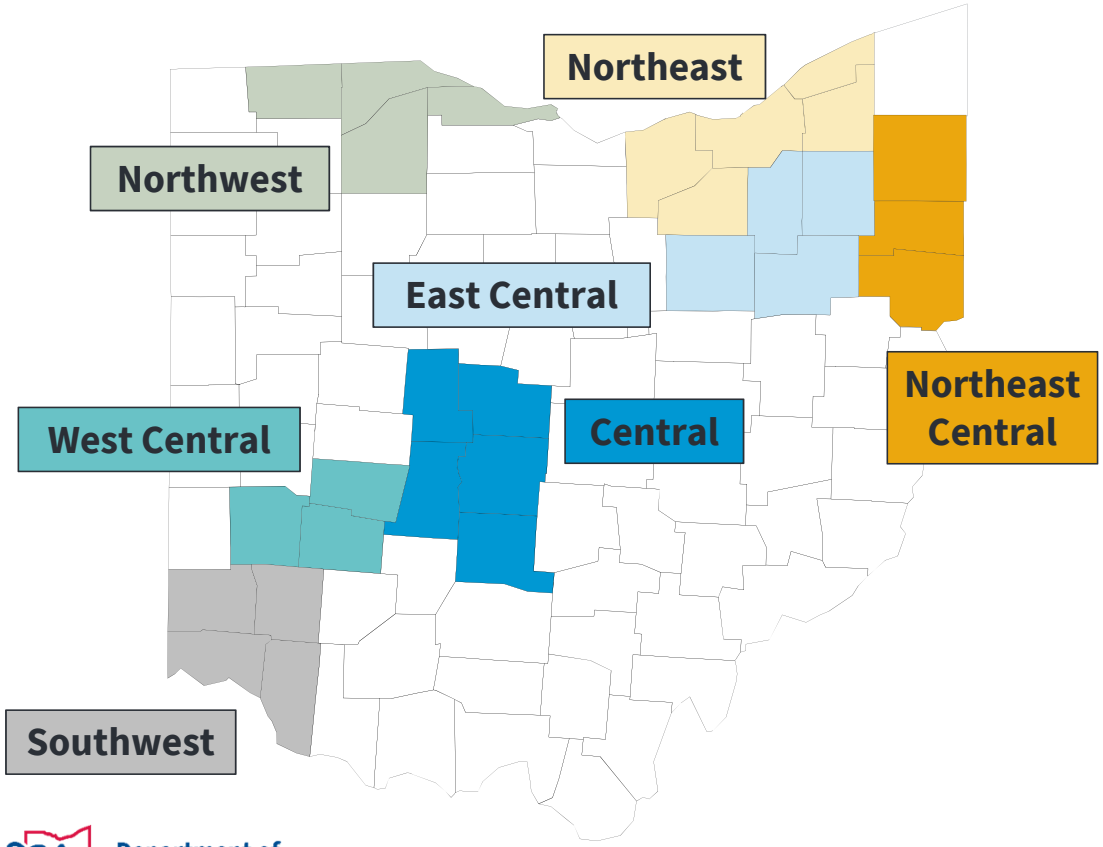
Member eligibility criteria

To enroll, you must be:

- Eligible for both Medicare and Medicaid services;
- Age 18 and older; and
- Reside in one of the 29 demonstration counties.

MyCare Ohio regions

Where MyCare Ohio is currently available and plans by region



Region	MyCare Plans
Northwest	Aetna Buckeye
Northeast	Buckeye CareSource United
East Central	CareSource United
Northeast Central	CareSource United
West Central	Buckeye Molina
Southwest	Aetna Molina
Central	Aetna Molina

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Community based waiver services

To enroll in the waiver, you must receive one of the following services per month or annually*

- Adult day health services.
- Alternative meals service.
- Assisted living services.
- Choices home care attendant.
- Community transition.
- Personal emergency response services.
- Enhanced community living services.
- Home care attendant.
- Home delivered meals.
- Homemaker services.
- Home medical equipment and supplemental adaptive and assistive devices.
- Home modification.
- Home maintenance and chore.
- Community integration.
- Out of home respite services.
- Personal care services.
- Nutritional consultation.
- Social work counseling .
- Waiver nursing services .
- Waiver transportation.

**Based on waiver service requirements listed on slide 18.*

MyCare Ohio program changes*

What is changing with MyCare Ohio?

*Even with these changes, members can still choose to receive their Medicare benefits through a Medicare Advantage plan or Medicare fee-for-service if they would like.

MyCare Ohio program

- Expansion: Expanding MyCare Ohio program from 29 counties to statewide to allow all eligible Ohioans to receive needed care.
- Conversion: Implementation of Next Generation Medicaid program requirements and benefits into the MyCare Ohio program.
- MyCare Ohio program eligibility age is 21 years old.

Waiver services coordination

- Continues to offer all the same services available within the:
  - Ohio Home Care waiver.
  - PASSPORT waiver.
  - Assisted Living waiver.

Ohio Medicaid will go through a managed care entity selection process to determine which plans will serve individuals covered by the Next Generation of MyCare Ohio this year.

MyCare Ohio program changes (continued)

What is changing with MyCare Ohio?

Self-direction	Expanding self-direction to **give you more control over your waiver services**.
Transportation	Adding **additional member protections for transportation services** from the Next Generation managed care provider agreements.
Behavioral health	Increasing **focus on behavioral health care coordination**.

Additional changes are forthcoming and will be shared once we are further along in the selection process.

1115 Reentry Waiver Opportunity Overview

Kara Miller

Special Populations Section Chief

Ohio Department of Medicaid

Section 1115 Demonstration Opportunity to Support Reentry for Justice Involved Populations

April 17, 2023

Centers for Medicare & Medicaid Services (CMS) issued the State Medicaid Director letter #23-0003

Key Details

- Under section 1115, we have an opportunity to test transition-related strategies to support community reentry and improve care transitions for individuals who are incarcerated
- We can submit a waiver of the inmate exclusion to receive Federal Financial Participation (FFP) for Medicaid expenditures for certain pre-release health care services provided to incarcerated individuals eligible prior to their release

11 Approvals

CMS approved the first waiver (California) in January 2023. Montana, Washington, Massachusetts, Illinois, Kentucky, Oregon, Utah, Vermont, New Hampshire and New Mexico also received approval

13 Demonstration Requests

13 additional states have reentry demonstration requests

Section 1115 Demonstration Goals

- **Increase coverage, continuity of coverage, and appropriate service uptake** through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release
- **Improve access to services** prior to release and improve transitions and continuity of care into the community upon release and during reentry
- **Improve coordination and communication** between correctional systems, Medicaid systems, managed care plans, and community-based providers
- **Increase additional investments in health care and related services**, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release
- **Improve connections between carceral settings and community services** upon release to address physical health, behavioral health, and health-related social needs (HRSN)
- **Reduce all-cause deaths** in the near-term post-release
- **Reduce number of ED visits and inpatient hospitalizations** among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care

State Flexibility

This opportunity offers flexibility to states to provide coverage for certain pre-release services, individuals, and carceral facilities.

Eligible Facilities	Eligible Individuals	Minimum Covered Services	Eligible Providers	Time Period for Covering Pre-release Services
• Flexibility to provide coverage of pre-release services in state and local correctional facilities. • States may seek to provide services in all eligible facilities statewide or they can choose to only provide services in a subset of correctional facilities. • States may outline a phased approach throughout the duration of the demonstration.	• States define their populations of focus for pre-release services and eligibility criteria. • States may make all Medicaid-enrolled individuals in participating carceral facilities eligible. • States also define which Medicaid eligibility groups will be covered.	• CMS requires states to provide a minimum set of pre-release services (Case management, medication-assisted treatment (MAT) for all SUD with accompanying counseling, and medications – upon release. • States have flexibility to add services that support reentry into community (e.g., family planning services, screening for common health conditions such as blood pressure, diabetes).	• States must ensure that carceral providers comply with Medicaid participation requirements. • States have the flexibility to allow in-reach community-based providers or embedded carceral health providers to furnish services. • In reach providers may provide services in person or via telehealth.	• The time cannot exceed 30 days; however, several states are seeking additional time which CMS may allow if states document additional hypotheses related to longer duration of services yielding better outcomes.

Ohio will have to define the…

FACILITIES

- State Prisons
- County Jails
- Youth Correctional Facilities
- Subset of correctional facilities
- All eligible facilities statewide

INDIVIDUALS

- SUD
- Mental Illness
- Chronic health conditions
- Pregnant or 12-month post-partum
- Children / Youth
- Disabled

REENTRY SERVICES

- Minimum Required Services Include: Case Management, Medication Assisted Treatment (MAT), and 30-day supply of medication on release
- Family planning Services
- Screening for common health conditions
- Rehabilitation or preventative services
- Durable medical equipment & supplies

SERVICE PROVIDERS

- In-reach community-based providers
- Embedded carceral health providers

TIME PERIOD FOR PRE-RELEASE SERVICES

- 31-90 days
- Up to 30 days prior to release

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Stakeholder Engagement

CMS strongly encourages states contemplating submitting a demonstration application to engage individuals with lived experience who were formerly incarcerated in both the design and implementation of a state's Section 1115 Reentry Demonstration proposal

Stakeholder Engagement Timeline and Process

The stakeholder engagement process will include both educational components (e.g., an overview on what is or is not available via the 1115) and an opportunity to seek input from the various stakeholder populations (e.g., barriers to care and suggested strategies for improvement).

May

Events / Meetings
- Hold meeting with partner agencies to review and provide feedback on stakeholder engagement plan

Planning / Communications
- Begin identifying other partner organizations and gathering contact information

June

Events / Meetings
- Begin focus groups and targeted listening sessions with stakeholders

Planning / Communications
- Finalize list of partner organizations and contact information
- Develop stakeholder survey

July

Events / Meetings
- Hold final focus groups and targeted listening sessions with stakeholders

Planning / Communications
- Publish and distribute survey

August

Events / Meetings
- Hold wrap-up / findings meeting with partner agencies and other stakeholders (as needed)

Planning / Communications
- Develop final findings report

Stakeholder Engagement Schedule

No.	Stakeholder Group	Meeting Date/Time	Status
1	Justice/Legal	Monday, June 24th 11:30am	**Complete**
2	Law Enforcement	Wednesday, June 26th 3:00pm	**Complete**
3	Carceral Settings – 3 meetings: • Halfway houses/CBCFs • County Jails • CCFs/JDCs	• Halfway houses/CBCFs – Tuesday, June 25th 9:00am • CCFs/JDCs – Thursday, June 27th 8:30am • County Jails Tuesday – Friday, June 28th 1:30pm	**Complete**
4	County Stakeholders	Friday, June 28th 9:00am	**Complete**
5	Advocacy/Community Agencies	Tuesday, July 9th 9:00am	**Complete**
6	Foster Care/Youth Agencies	Monday, July 15th 1:00pm	**Complete**
7	BSSA Community Corrections-Medicaid 1115 & Reentry sub-committee	Tuesday, July 16th 9:30am	**Complete**
8	Health Providers	Wednesday, July 17th 9:00am	**Complete**
9	MCOs	Friday, July 19th 9:00am	**Complete**
10	Hospitals	Tuesday, July 23rd at 9:30am	**Complete**
11	General Information Session	Friday, July 26th 9:30am	**Complete**

Note: ODM will seek input from individuals with lived experience via a survey that will be distributed in July

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