Ohio Medicaid Update

Ohio Association of County Boards Spring Conference
May 11, 2017

Barbara R. Sears, Medicaid Director
Our Mission

Providing accessible and cost effective health care coverage for Ohioans by promoting personal responsibility and choice through transformative and coordinated quality care.
Our Vision

We are dedicated to being a national leader in health care coverage innovation that improves the lives of Ohioans and strengthens families.
Ohio Medicaid

• Medicaid is Ohio’s largest health payer.

• Over 90,000 hospitals, nursing homes and other providers deliver services for over 3 million individuals insured by Medicaid.

• Over 2.4 million Medicaid enrollees are served by the five statewide managed care plans (MCPs)
Ohio Medicaid Enrollment Overview

- January 2017 enrollment: 3,054,806
- 89% covered by a managed care plan
- Children in Custody, Adopted Children, BCCP Individuals, Medicaid eligible individuals enrolled in BCMH Program are currently served by a managed care plan
- As of January 1, 2017 there are 714,997 covered in the expansion category
  - All enrolled or enrolling in private managed care plans
- Long-term services and supports: approximately 88,000 served by HCBS waivers; 56,000 living in long-term care facilities
Rebuild Community Behavioral Health System Capacity
‘Over Budget Neutral’ Investments:

- Total of **$53.4M above budget neutrality** point due to below updates and all previously communicated updates in response to stakeholder feedback

1. Rate increases for Registered Nurse (RN) and Licensed Practical Nurse (LPN) services
2. Rate increases for all Evaluation and Management (E&M) services
3. Modification of the required years of experience for individuals to render Therapeutic Behavioral Services (TBS)
4. Coding guidance for ASAM Outpatient Level of Care 1, SUD Group Counseling

*Please keep in mind that all proposed changes are still subject to approval by CMS*
Rebuild Community Behavioral Health System Capacity

Ohio’s Behavioral Health Transformation:

• **Elevation.** Shifted Medicaid match responsibility from local mental health and addiction treatment systems to the state

• **Expansion.** Extended Medicaid coverage to 500,000 residents with behavioral health needs who previously relied on county-funded service or went untreated

• **Modernization.** Updated Medicaid behavioral health billing codes to match national insurance standards and expanded services for individuals with the most intense needs

• **Integration.** Moving the Medicaid behavioral health benefit into managed care beginning January 1, 2018
Rebuild Community Behavioral Health System Capacity

The Governor’s Budget Modernizes the Medicaid Benefit:

• Revises services coding for the first time in decades (provider manuals are posted online)
• Expands Medicaid rehabilitation options and supports a new Specialized Recovery Services program (replaces spenddown)
• Moves all Medicaid behavioral health services into managed care January 1, 2018, as required by the last budget
• Provides Medicaid reimbursement for freestanding psychiatric hospitals beginning July 1, 2017
Rebuild Community Behavioral Health System Capacity

The Governor’s Budget Strengthens Community Supports:

- Assists prisoners with addiction transition to the community
- Encourages community innovations to avoid incarceration
- Supports addiction treatment for court-involved individuals
- Strengthens community prevention services
- Reduces preschool expulsions
- Continues support for Strong Families, Safe Communities
- Supports crisis hotlines and adds a text option
- Supports residency and traineeship programs for in-demand behavioral health professionals
Pay for Value
Ohio’s State Innovation Model (SIM) progress to date

### Comprehensive Primary Care
- **Care model and payment model** design in place for model to reach 80 percent of Ohio’s population
- **Statewide provider survey** gauged readiness
- **Infrastructure plan** in place for attribution, enrollment, scoring, reporting, and payment
- **Ohio CPC performance report** designed with provider/payer input
- **All payers applied for Ohio to be a statewide Medicare CPC+ region**

### Episode-Based Payment
- **13 episodes** designed across seven clinical advisory groups (CAGs)
- **30 additional episodes** under development to launch in 2017
- **Nine payers** released performance reports on first wave of 6 episodes
- State set **thresholds for performance** payments across Medicaid FFS and MCPs on first wave of episodes
- State released **performance reports** aggregated across Medicaid FFS and MCPs on second wave of 7 episodes
- **Executive Order** and rule require Medicaid provider participation
Multi-payer participation is critical to achieve the scale necessary to drive meaningful transformation
Increase access and transparency to comprehensive primary care

• As part of our efforts with our State Innovation Model (SIM) grant work, we will invest $124 million over two years in comprehensive primary care
• Financially reward primary care practices that do more to keep patients well
• Make health care price and quality information more transparent
• Create greater accountability between episode providers and primary care
• Set clear priorities to improve population health
Make Health Care Price and Quality Transparent

Primary Care Performance Report

Episode Performance Report

Referral

Patient Activity Report for Primary Care

Report
Ohio CPC “Early Entry” Practice Eligibility  
(January 1, 2017 to December 31, 2017)

**Required**

- Eligible provider type and specialty
- One of the following characteristics:
  - Practice with 5,000+ attributed Medicaid individuals and national accreditation
  - Practice with 500+ attributed Medicaid individuals determined through claims-only data at each attribution period and NCQA III accreditation
  - Practice with 500+ attributed Medicaid individuals at each attribution period and enrolled in Medicare CPC+
- Commitment:
  - To sharing data with contracted payers/ the state
  - To participating in learning activities
  - To meeting activity requirements in 6 months

**Not required**

- Planning *(e.g., develop budget, plan for care delivery improvements, etc.)*
- Tools *(e.g., e-prescribing capabilities, EHR, etc.)*

---

1 Eligible accreditations include: NCQAII/III, URAC, Joint Commission, AAAHC
2 Examples include sharing best practices with other CPC practices, working with existing organizations to improve operating model, participating in state led CPC program education at kickoff
## Ohio Comprehensive Primary Care (CPC) Program Requirements and Payment Streams

### Requirements

**8 activity requirements**
- Same-day appointments
- 24/7 access to care
- Risk stratification
- Population management
- Team-based care management
- Follow up after hospital discharge
- Tracking of follow up tests and specialist referrals
- Patient experience

**4 Efficiency measures**
- ED visits
- Inpatient admissions for ambulatory sensitive conditions
- Generic dispensing rate of select classes
- Behavioral health related inpatient admits

**20 Clinical Measures**
- Clinical measures aligned with CMS/AHIP core standards for PCMH

### Total Cost of Care

- Must pass 50%
- Must pass 100%
- Must pass 50%

---

**Payment Streams**

<table>
<thead>
<tr>
<th>PMPM</th>
<th>Shared Savings</th>
<th>Practice Transformation Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All required</strong></td>
<td><strong>All required</strong></td>
<td><strong>TBD for select practices</strong></td>
</tr>
</tbody>
</table>
Ohio’s episode timeline

Wave 1: Perinatal, asthma, COPD, Acute PCI, Non-acute PCI, total joint replacement
- Reporting only
- Performance Y1
- Performance Y2
- Performance Y3

Wave 2: URI, UTI, cholecystectomy, appendectomy, upper GI endoscopy, colonoscopy, GI hemorrhage
- Reporting only
- Performance Y1
- Performance Y2

Wave 3: Preliminary: HIV, Neonatal (3 episodes), Hysterectomy, Pancreatitis, Skin and soft tissue infection, Diabetic ketoacidosis, Lower back pain, Headache, CABG, Cardiac valve, Congestive heart failure, Breast cancer surgery, Breast medical oncology, Mastectomy, Otitis, Pediatric acute lower respiratory infection, Tonsillectomy, Shoulder sprain, Wrist sprain, Ankle sprain, Knee sprain, Hip/Pelvic fracture, Knee arthroscopy, Spinal fusion exc. cervical, Spinal decompression, Adult pneumonia, Syncope, Lung cancer medical oncology, Lung cancer surgery, Lung cancer radiation, ADHD, Oppositional defiant disorder
- Reporting only
- Performance Y1
Report transparency and performance on high-cost episodes of care

• Share savings with health care providers that achieve high quality at low costs
• Make health care price and quality information transparent
• Create greater accountability between episode providers and primary care
• Set clear priorities to improve population health
Make health care cost and quality transparent

• Combine health care price and quality information to determine value
• Focus first on the most “shoppable” services
• Create a framework to help consumers choose high-value health plans and providers
• Set clear priorities to improve population health
• Build public support for price and quality transparency
Improve Program Performance
Implement a competitive transportation brokerage system

- As early as July 2019, responsibility for non-emergency medical transportation will transition from a county-based system to a regional-based brokerage model.

- Funding will transition from the Ohio Department of Job and Family Services to the Ohio Department of Medicaid.

- Ohio will be able to draw down more federal funds (from 50% to 62% match) saving over $6.8 million annually.
State-based transportation brokerage model

• Ohio Medicaid will contract with third party transportation broker(s) to manage non-emergency medical transportation.

• Contracts with the transportation broker and transportation providers will include standards to ensure consistent response times, scheduling and provision of transportation services for individuals, regardless of where they are located within the state.

• Contracts will utilize existing local transportation resources.

• This model will streamline the process for Medicaid enrollees to secure reliable transportation and access care.
Improve Care Coordination
Managed Long Term Services and Supports
A few high-cost cases account for most Medicaid spending

1% of the Medicaid population consumes 25% of total Medicaid spending

4% of the Medicaid population consumes 53% of total Medicaid spending

The bulk of Medicaid’s costs come from its dominant role in delivering mental health benefits, a variety of services for individuals with physical, developmental and intellectual disabilities, and long term care.

Source: Ohio Department of Medicaid, state fiscal year 2016 for all Medicaid populations and all medical (not administrative) costs
<table>
<thead>
<tr>
<th>Fragmentation vs. Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Multiple separate providers</td>
</tr>
<tr>
<td>• Provider-centered care</td>
</tr>
<tr>
<td>• Reimbursement rewards volume</td>
</tr>
<tr>
<td>• Lack of comparison data</td>
</tr>
<tr>
<td>• Outdated information technology</td>
</tr>
<tr>
<td>• No accountability</td>
</tr>
<tr>
<td>• Institutional bias</td>
</tr>
<tr>
<td>• Separate government systems</td>
</tr>
<tr>
<td>• Complicated categorical eligibility</td>
</tr>
<tr>
<td>• Rapid cost growth</td>
</tr>
<tr>
<td>• Accountable medical home</td>
</tr>
<tr>
<td>• Patient-centered care</td>
</tr>
<tr>
<td>• Reimbursement rewards value</td>
</tr>
<tr>
<td>• Price and quality transparency</td>
</tr>
<tr>
<td>• Electronic information exchange</td>
</tr>
<tr>
<td>• Performance measures</td>
</tr>
<tr>
<td>• Continuum of care</td>
</tr>
<tr>
<td>• Aligned priorities</td>
</tr>
<tr>
<td>• Streamlined income eligibility</td>
</tr>
<tr>
<td>• Sustainable growth over time</td>
</tr>
</tbody>
</table>
Rationale for moving to MLTSS

• Provides the benefits of care coordination to Medicaid enrollees who have the most complex needs
• Creates a system where health care providers are incentivized to keep patients healthy and eliminate gaps in service;
• Strengthens the focus on quality measurement, including both quality of life and quality of care, in order to achieve better outcomes;
• Ensures transparency, accountability, effectiveness and efficiency of the program; and
• Ensures long-term sustainability of the system as demand for LTSS grows by controlling costs.
100 residents enrolled in managed care had to be evacuated when nursing facility’s air conditioning failed during humid, 90-degree days.

Many residents had complex mental health care needs and had lived in the facility for many years.

Care managers moved all residents into appropriate, air-conditioned facilities within five days.
Near Evacuation Unlikely to Have Gone Well

• 87 non-managed care residents were in potential danger when furnace failed in November.
• NF did not have required emergency backup plan. NF’s plan was to take residents to hospital.
• Fortunately, heat was fixed before evacuation was required. However, without organized coordination of managed care plan, long-term ombudsmen would have had to evacuate the residents with less efficiency and speed.
Implement a Multi-dimensional Quality Strategy for MLTSS

• Standardize healthcare measures used nationally (HEDIS)
• Individual satisfaction survey (CAHPS)
• ODM specific measures
Examples of Measures

- Nursing home diversion & transition measures
- Reducing pressure ulcers in nursing home residents
- Appropriate follow-up after in-patient psychiatric stay
- Controlling high blood pressure
Ensuring MLTSS Success in Ohio

• Based on key elements identified by the National Association of States United for Aging and Disabilities for a successful MLTSS program, Ohio plans to adopt:
  – Strong care coordination requirements and structure
  – Network adequacy standards
  – Provider contracting and training at start-up
  – Consumer protections (ombudsman, strong choice counseling)
  – Strong state agency management controls and health plan accountability mechanisms (contract language and financial consequences)
MAKING OHIO BETTER