JMOC Update

Barbara R. Sears, Director
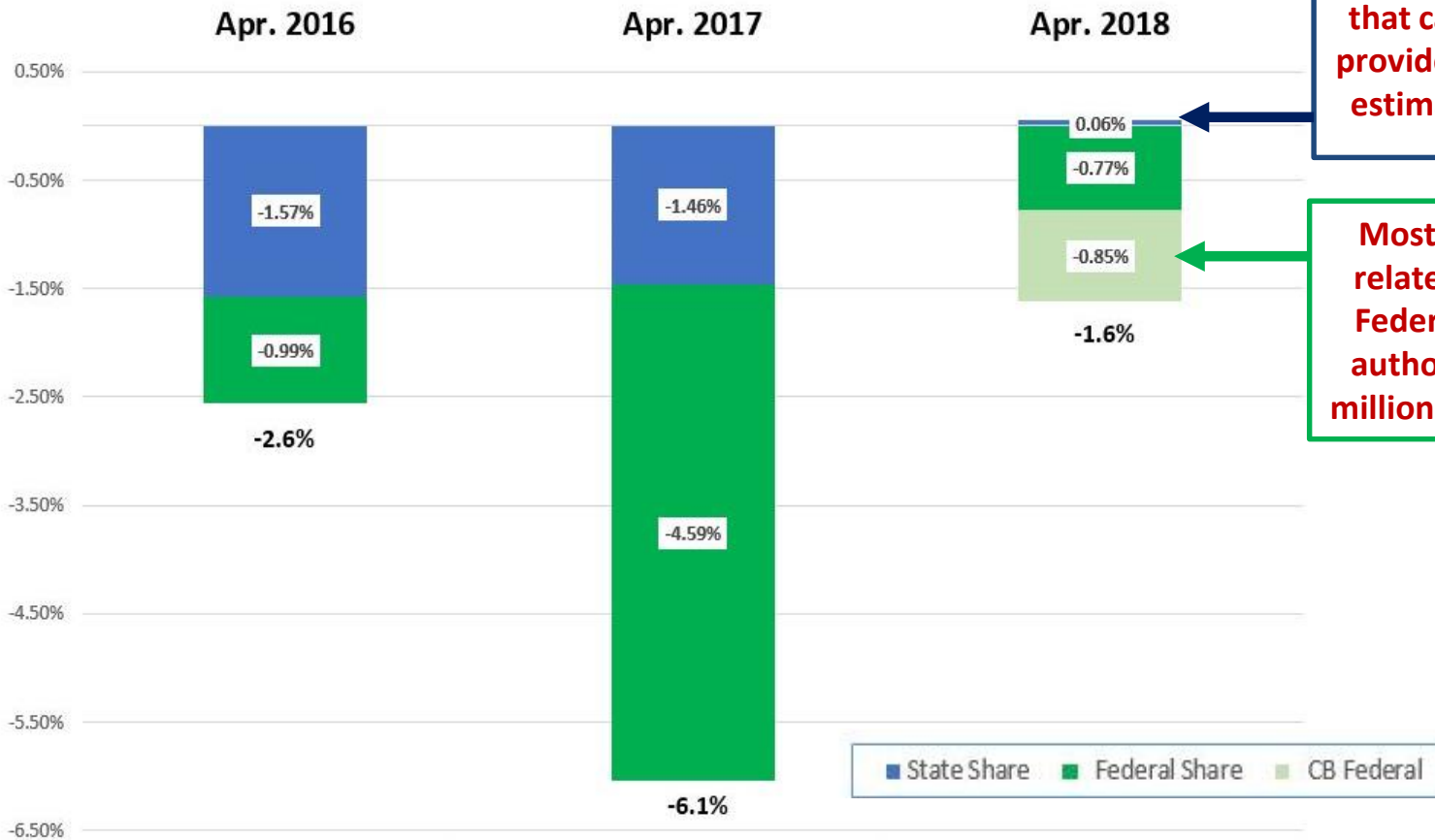Ohio Department of Medicaid
May 10, 2018

TODAY'S AGENDA

- **Ohio Medicaid Budget**

- BH Redesign – impact of 1/1 coding changes

- BH Redesign – readiness for 7/1 integration

- Discussion

Ohio Medicaid Budget Variance

(Appropriation Line Item 651625)

The state share of 651525 that can be used to fund provider payments is over estimate by $6.6 million

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

Apr. 2016

- -1.57%
- -0.99%
- **-2.6%**

Apr. 2017

- -1.46%
- -4.59%
- **-6.1%**

Apr. 2018

- 0.06%
- -0.77%
- -0.85%
- **-1.6%**

Legend: ■ State Share ■ Federal Share ▪ CB Federal

SOURCE: Ohio Department of Medicaid (May 2018).

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Medicaid Budget Activities in May …

- Medicaid budget reprojection
- Hospital recalibration (underway)
- Hospital/Physician upper payment limit adjustments
- Hospital FY19 5% rate reduction (if needed)
- Prepare FY19 CB release of funds ($311 million)

TODAY'S AGENDA

- Ohio Medicaid Budget

- **BH Redesign – impact of 1/1 coding changes**

- BH Redesign – readiness for 7/1 integration

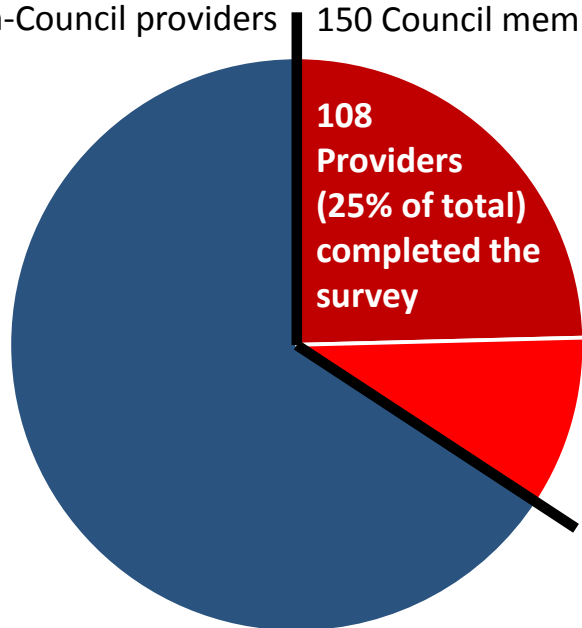- Discussion

Ohio Council Provider Survey Results

- "An astounding 80% of members completed the survey"

- "61% of providers report receiving less than 80% of budgeted Medicaid revenue since redesign implementation"

- "Claim denials exceed the normal 11% average rate"

- "To manage Medicaid payment delays in April and June, providers used a combination of strategies to survive"

- "56% of providers have less than 60 days cash on hand"

- "81% of providers reported starting the MCO contracting and credentialing process"

SOURCE: The Ohio Council, *Medicaid BH Redesign Provider Survey Results* (April 18, 2018)

Ohio Council Provider Survey Results

"An astounding 80% of members completed the survey."

439 Providers Total (type 84/95)

289 non-Council providers | 150 Council members

108 Providers (25% of total) completed the survey

NOTE: Earlier presentations identified 636 providers, but that count duplicated providers who are both type 84 and 95. There are 439 individual providers, including 84 only, 95 only, and 84/95 combined (April 2018).

- **The Council survey represents 25% of the providers impacted by redesign**
- Only The Council is advocating a delay
- Other associations are working with the state toward July 1 integration
  - NAMI Ohio
  - Ohio Association of Child Caring Agencies
  - Ohio Children's Hospital Association
  - Ohio Hospital Association
  - Ohio Association of Health Plans
  - Ohio Association of County Behavioral Health Authorities

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Working together toward integration …

Ohio Departments of Medicaid and MHAS	Medicaid Managed Care Plans
• Reached over **5,600 individuals** through **38 state sponsored trainings** statewide	• Reached **1,660 individuals** through three series of **provider forums** statewide

OACCA
Provided Training and TA
- Rapid cycle change program
- BH Middle Management Academy

OACBHA
Sponsored multiple regional BH Redesign Trainings

OAHP
Facilitated multiple regional BH Redesign Forums

• Regularly engaged with **29 software vendors** through **21 meetings** of the EDI/IT Work Group	— Webinars
• Since the launch of the BH Redesign website, over **173,900 total page views**	— Regional walk-in office hours
	— Training videos
	— Messages on provider websites

SOURCE: Ohio Department of Medicaid (May 2018).

Working together toward integration …

The state is coordinating rapid response services requested by NAMI:

Ohio Department of Medicaid:
- Medicaid Consumer hotline: 1-800-324-8680
- Medicaid Provider hotline: 1-800-686-1516 (option 9)
- Beneficiary Ombudsman: Sherri Warner (Phone: 614-752-4599; Sherri.Warner@medicaid.ohio.gov)

Ohio Department of Mental Health and Addiction Services:
- Client Rights and Advocacy Resources (link)

Local Resources:
- National Alliance on Mental Illness helpline: 1-800-686-2646
- Ohio Association of County Behavioral Health Authorities, Board Directory (link)
- NAMI or a county board can escalate any issue to the Beneficiary Ombudsman

Specialized Recovery Services (SRS) Resources:
- CareSource SRS Program Manager: Dawn Rist-Opal (Phone: 216-618-8124; Dawn.RistOpal@CareSource.com)
- Council on Aging SRS Program Manger: Christy Nichols (Phone: 513-592-2779; Cnichols@help4seniors.com)
- CareStar SRS Program Manager: Mike Swiderski (Phone: 614-729-1006 x4834; mswiderski@carestar.com)

SOURCE: Ohio Department of Medicaid, *Behavioral Health Redesign Triage Process Commitment* (May 15, 2017).

Ohio Council Provider Survey Results
"61% report receiving less than 80% of budgeted Medicaid revenue*"*

Medicaid BH paid amounts (Q1 2017 and 2018)

Period	2017 Monthly Payments	2018 Monthly Payments	Difference
February	$97,924,101	$78,444,423	-20%

SOURCE: Ohio Administrative Knowledge System (OAKS) payments to providers as reported in the Ohio Department of Medicaid FLASH Reports (May 2018).

Monitoring monthly payments ...

Medicaid BH monthly payments (Q1 2017 and 2018)

Period	2017 Monthly Payments	2018 Monthly Payments	Difference
January	$96,723,592	$98,251,947	2%
February	$97,924,101	$78,444,423	-20%
March	$98,820,584	$96,676,679	-2%
Q1 Total	**$293,468,276**	**$273,373,049**	**-7%**

SOURCE: Ohio Administrative Knowledge System (OAKS) payments to providers as reported in the Ohio Department of Medicaid FLASH Reports (May 2018).

Why are BH payments 7% less than last year?

Is it because the new system is …

- Denying too many claims?

- Not paying claims that the old system paid?

- Restricting cash flow?

- Forcing providers out of the system?

- Restricting patient access to services?

Ohio Council Provider Survey Results
"Claim denials exceed the normal average 11% rate"

Medicaid BH claims denied based on original claims (Q1 2018)

Period	Original Claims			Paid	Denied	Denied Rate
January	237,484			170,636	66,848	28%
February	981,096			751,302	229,794	23%
March	1,696,347			1,391,833	304,514	**18%**
Q1 Total	**2,914,927**			**2,313,771**	**601,156**	**21%**

NOTE: Includes claims submitted and adjudicated in Q1 2018.
SOURCE: Ohio Department of Medicaid (May 2018).

The new system pays more accurately

Medicaid BH claims denied after compliance edits (Q1 2018)

Period	Original Claims	Compliance Edits	Allowable Claims	Paid	Denied	Denied Rate
January	237,484	18,741	218,743	164,907	53,836	25%
February	981,096	89,560	891,536	725,658	165,878	17%
March	1,696,347	169,178	1,527,169	1,342,465	184,704	**11%**
Q1 Total	**2,914,927**	**277,479**	**2,637,448**	**2,233,030**	**404,418**	**15%**

- The old system identified duplicate claims – but the new system can also identify non-Medicaid claims, third-party liability, National Correct Coding Initiative (NCCI) standard violations, and outdated codes that are no longer in use

- **These claims –** *which providers should not have submitted* **– can now be removed during a compliance edit <u>prior to</u> consideration for payment**

Denials are below historic norms for most

Medicaid BH claims after compliance edits and removing 26 high-denied providers (Q1 2018)

Period	Original Claims	Compliance Edits	Allowable Claims	Paid	Denied	Denied Rate
January	237,484	120,381	117,103	102,566	14,537	12%
February	981,096	388,223	592,873	526,743	66,130	7%
March	1,696,347	666,886	1,029,461	944,785	84,676	**5%**
Q1 Total	**2,914,927**	**1,175,490**	**1,739,437**	**1,574,094**	**165,343**	**6%**

- In addition, 26 providers (6%) account for most (41%) denied claims:

- **When the 26 outliers are removed, the rate of claims denied drops well below historic norms for the remaining 413 providers**

NOTE: Includes claims submitted and adjudicated in Q1 2018.
SOURCE: Ohio Department of Medicaid (May 2018).

Experience further reduces claims denied

Medicaid BH hospital claims after compliance edits (Q1 2018)

Period	Allowable Claims	Paid	Denied	Denied Rate
January	6,411	6,359	52	0.8%
February	6,162	6,082	80	1.3%
March	5,769	5,715	54	0.9%
Q1 Total	**18,342**	**18,156**	**186**	**1%**

- Hospitals were already familiar with national standard code sets and started using the new system in August 2017
- As a result, denials are very low – and achievable by other providers

SOURCE: Ohio Department of Medicaid (May 2018).

Ohio Council Provider Survey Results

Ohio Council BH Redesign Survey Results (April 2018)

- "56% of provider organizations have LESS than 60 days cash on hand with 37% having LESS than 30 days."

Ohio Council Legislative Testimony (March 2017)

- "… providers in this system have limited cash reserves with 58% having less than 60 days cash on hand and 39% have less than 30 days cash on hand."

Ohio Council Provider Survey Results

"56% of providers have less than 60 days cash on hand ..."

Average number of days between:

Period			Service date and payment date
2017			
January			15.1
February			15.0
March			23.1
2018			
January			14.9
February			21.2
March			27.5

+4.4 days

NOTE: Based on claims submitted and paid in the first quarter of 2017 and 2018.
SOURCE: Ohio Department of Medicaid (May 2018).

The new system pays providers promptly

Average number of days between:

Period	Service date and claim submission date	Claim submitted date and payment date	Service date and payment date
2017			
January	7.0	8.0	15.1
February	6.7	8.3	15.0
March	14.6	8.5	23.1
2018			
January	7.0	7.9	14.9
February	12.8	8.4	21.2
March	19.2	8.3	27.5

-0.2 days

NOTE: Based on claims submitted and paid in the first quarter of 2017 and 2018.
SOURCE: Ohio Department of Medicaid (May 2018).

Ohio Council Provider Survey Results
"... Medicaid payment delays in April and June ..."

- The fiscal year 2018-2019 budget reduced the Medicaid appropriation below the amount needed to run the program

- Ohio Medicaid implemented a contingency plan to keep spending within the budget's final appropriation levels

- A one-week payment delay for all providers results in one-time savings ($66 million) but, because Medicaid pays most claims within 10 days, stays well within the 30-day industry standard for prompt payment

- In April 2017, Ohio Medicaid implemented a one-time, one-week payment delay, and is considering a similar delay in June

- **Based on the Medicaid budget reprojection later in May, Ohio Medicaid will assess whether or not the June payment delay is needed**

# Patients have more choice of providers

- Redesign allows hospitals to bill Medicaid directly for outpatient behavioral health services (without provider type 84/95 certification)
  - 8 hospitals switched from provider type 84/95
  - As a result, the BH claims paid to these hospitals appear in the 84/95 claims tracker in 2017 ($2.2 million in Q1) but not in 2018
  - **An additional 16 hospitals (+200%)** have opted to provide BH services
- The number of behavioral health type 84/95 providers (not including hospitals) **increased by 41 providers (+10%)** since January 2017

Period	Provider Type 84 (excluding hospitals)	Provider Type 95 (excluding hospitals)	Total 84/95	Unduplicated
January 2017	307	266	573	**398**
April 2018	331	305	636	**439**

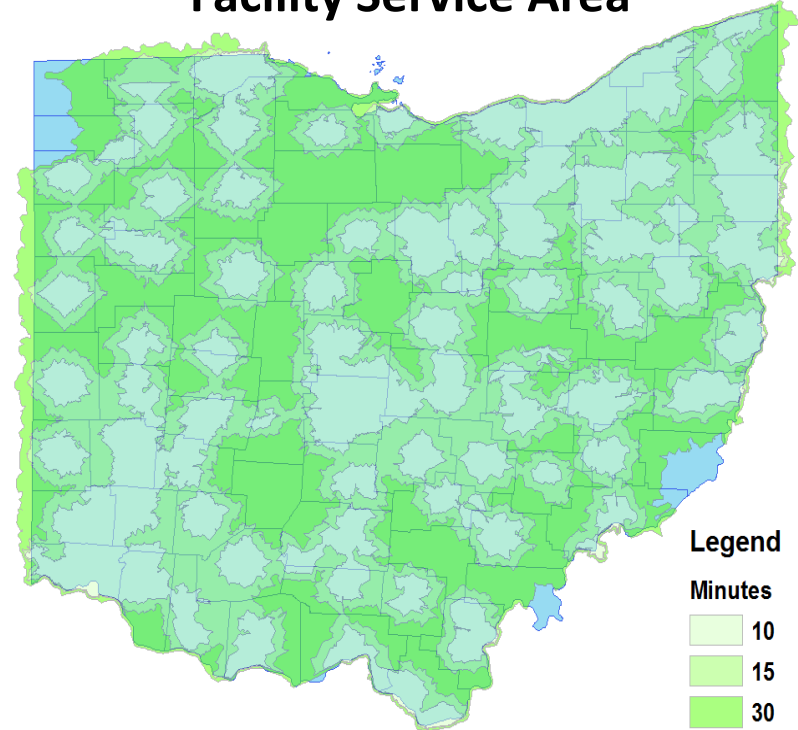**+10%**

SOURCE: Ohio Department of Medicaid (May 2018).

Patient access to care remains strong

2017 Q1 Behavioral Health Facility Service Area
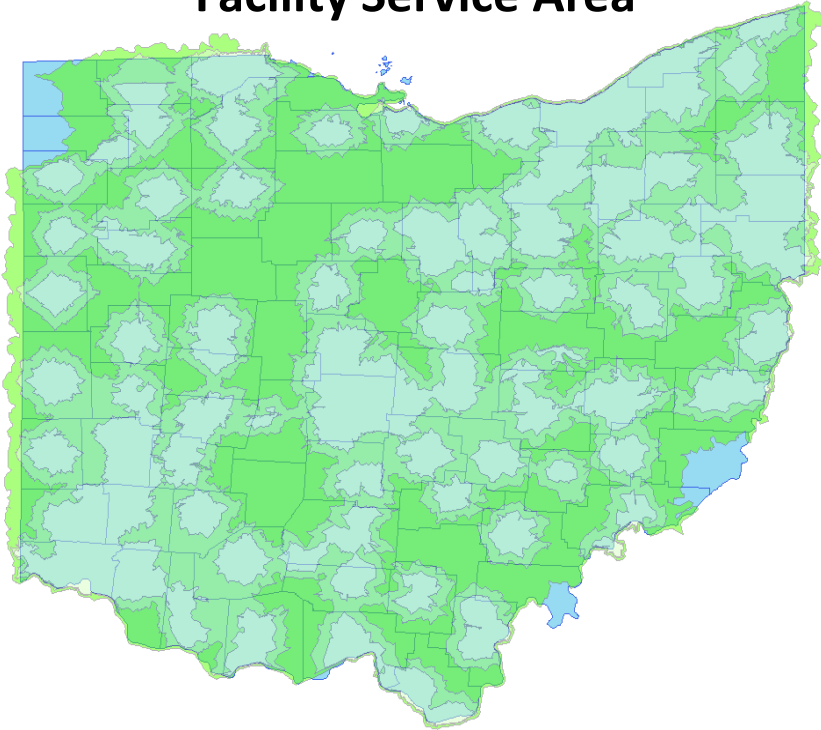
2018 Q1 Behavioral Health Facility Service Area

Legend

Minutes
- 10
- 15
- 30

Note: These maps do not include satellite office locations nor locations for services that occur outside of a facility.
SOURCE: Ohio Department of Medicaid (May 2018).

Patients are receiving new services

- Expanded opioid treatment programs
- Expanded Substance Abuse Disorder (SUD) benefit package:
  —SUD Peer Recovery Support
  —SUD Partial Hospitalization
  —SUD Residential Care
- Intensive Home-Based Treatment (IHBT) for youth
- Assertive Community Treatment (ACT) for adults
- Primary care, labs and vaccines provided by BH provider
- Coverage for psychological testing
- Expanded eligibility for children's respite

NOTE: Expanded opioid treatment programs effective January 2017; all other effective January 2018.
SOURCE: Ohio Department of Medicaid (May 2018).

We know who is providing services

Practitioner	Number
Physician	1,050
Physician's Assistant	49
Clinical Nurse Specialist	90
Nurse Practitioner	506
Psychologist	282
Nurse	1,778
Social Worker*	2,293
Clinical Counselor*	2,311
Marriage and Family Therapist*	49
Chemical Dependency Counselor*	588

- This information was not available in the old system – the practitioner rendering the service was unknown
- The old system paid everyone on this list the same amount based on the service, not their training or level of skill
- The new system pays based on the service provided – but also takes into account the training and skill of the provider

* Represents highest level of licensure under each category
SOURCE: Ohio Department of Medicaid (May 2018).

Providers are adapting to redesign

Providers paid more under redesign in Q1 2018 than in Q1 2017 for services provided in those quarters:

A Haven for Kids, Inc
A New Day Lodi, LLC
Access Counseling Services, LLC
Alternative Paths, Inc.
Alvis, Inc.
Cedar Ridge Behavioral Health Solutions, LLC
Center for Addiction and Treatment
Community Behavioral Health Center
Comprehensive Behavioral Health
Cornell Abraxas Group, Inc.
Counseling Center of Wayne/Holmes Counties
Eastway Corporation
Empowered for Excellence
Family Pride of NE Ohio, Inc.
Harbor
Integrated Services for Behavioral Health
Jewish Family Service Association
L & P Services, Inc.

Magnolia Clubhouse, Inc.
Maumee Valley Guidance Center
Meridian Healthcare
Murtis Taylor Human Services System
National Youth Advocate Program
Pastoral Counseling Service of Summit County
Perry Behavioral Health Choices
Pickaway Area Recovery Services, Inc.
Shaker Clinic, LLC
Shelby County Counseling Center
St. Joseph Orphanage
Summit Psychological Association, Inc.
Sunrise Treatment Center, LLC
Syntero, Inc.
TASC of NW Ohio
TCN Behavioral Health Services, Inc.
Travco Behavioral Health, Inc.

NOTE: **Ohio Council members in bold** and *OACCA members in italics*
SOURCE: Ohio Department of Medicaid; Ohio Council and Ohio Association of Child Caring Agencies website (May 2018).

Impact of BH Redesign coding changes

Early Concerns	Redesign Performance
Claims denied exceed the normal 11% rate	Claims denied are less than historic norms for most providers (94%); a few providers (6%) account for most denials (41%)
Claims are being denied that the old system paid	Correct, the new system identifies claims that are not payable by Medicaid and removes them prior to consideration for payment
Claims are not paid promptly, disrupting cash flow	Claims are paid within 10 days (same as the old system) and much faster than prompt payment requirements (30 days)
Monthly payments are significantly less this year	February payments were 20% below last year, but March rebounded and was only 2% below last year
Providers are being forced out of the system	The number of BH providers increased 10% from 398 to 439 and hospitals providing outpatient BH services increased 200% from 8 to 24
Patients are not getting the services they need	Access to care remains strong statewide and patients benefit from new services, including expanded opioid treatment and substance abuse disorder benefits, IHBT for youth, ACT for adults, psychological testing, children's respite, and primary care, labs and vaccines from BH providers

SOURCE: Ohio Department of Medicaid (May 2018).

TODAY'S AGENDA

- Ohio Medicaid Budget
- BH Redesign – impact of 1/1 coding changes
- **BH Redesign – readiness for 7/1 integration**
- Discussion

Managed Care Integration Readiness – Introduction

- The Managed Care Plans will be ready for integration on July 1

- Most providers will be ready for integration on July 1

- Ohio Medicaid and the MCP's will continue extensive outreach and technical assistance until it is no longer necessary

- Ohio Medicaid is implementing safeguards to ensure the transition is as smooth as possible

- For Providers who are not ready, ODM is prepared to implement a contingency plan to help mitigate provider risk

Readiness Reviews

- The Ohio Department of Medicaid (ODM) is completing a thorough review of data and a preliminary desk review of MCP status for July 1 integration

- In conjunction with Mercer Government Human Services Consulting, ODM is conducting an onsite review at each managed care plan to thoroughly assess readiness to administer expanded behavioral health benefits.

- Readiness Review team includes:
  - » ODM Managed Care Compliance Team
  - » ODM Policy Subject Matter Experts
  - » Contractor Resources: Claims Review Auditors and Subject Matter Experts

Reminder: MyCare Ohio Readiness Review

- Desk and full day onsite reviews were conducted for each managed care plan.

- The MyCare Ohio plans were given 211 state-defined scenarios to run through their systems.

MyCare Ohio Plan	No. of Scenarios Tested	% Passed (October)	% Passed (December)
Aetna	211	84.83%	100.00%
Buckeye	211	77.73%	100.00%
CareSource	211	90.52%	98.58%
Molina	211	94.79%	100.00%
United Healthcare	211	83.89%	96.21%

Readiness (May 7 – May 11)

- Administrative Requirements
- Personnel Requirements
- Member Services
- Provider Network
- Utilization Management
- Claims and IT
  - Testing
  - Clearinghouse/Trading Partners
  - Internal Claims Audits
  - Encounter Data Testing
- Review of MyCare Ohio claims – MCPs are asked to prepare an Excel document of all claims from the January 1, 2018 expansion.

MCP vs. Provider Readiness Requirements

| Key Implementation Area	MCP Readiness Requirement	BH Provider Readiness Requirement
Ensure appropriate submission and receipt of prior authorization requests	Mandatory	Voluntary
Systems Testing	Mandatory	Voluntary
Internal Claims Audit Testing	Mandatory	Voluntary
Testing with Trading Partners and Clearinghouses	Mandatory	Voluntary
Testing of 211 possible billing scenarios	Mandatory	Voluntary (only asked to test scenarios specific to business)
Participate in Beta Testing	Mandatory	Voluntary
Contracting and credentialing process followed	Mandatory	Voluntary
Staffing and training	Mandatory	Voluntary

Prompt Pay:
My Care Experience
January-March 2018

Prompt Pay Compliance Penalties

- Behavioral health is a category of compliance for both the 30-day and the 90-day requirement. Compliance actions are:
    - » First Instance: Assess a refundable financial sanction equal to .04% of the average monthly net premium for the twelve months prior to the month in which the compliance action is issued, for each claim type and timeframe separately.
    - » Second Instance: Assess a nonrefundable financial sanction equal to .08% of the average monthly net premium for the twelve months prior to the month in which the compliance action is issued, for each claim type and timeframe separately.
    - » Subsequent violations during a rolling 12-month period may result in an enrollment freeze of not less than 3 months duration or until the MCP has come back into compliance.

Clean BH Claims Paid or Denied - 30 Days (Q1 2018)
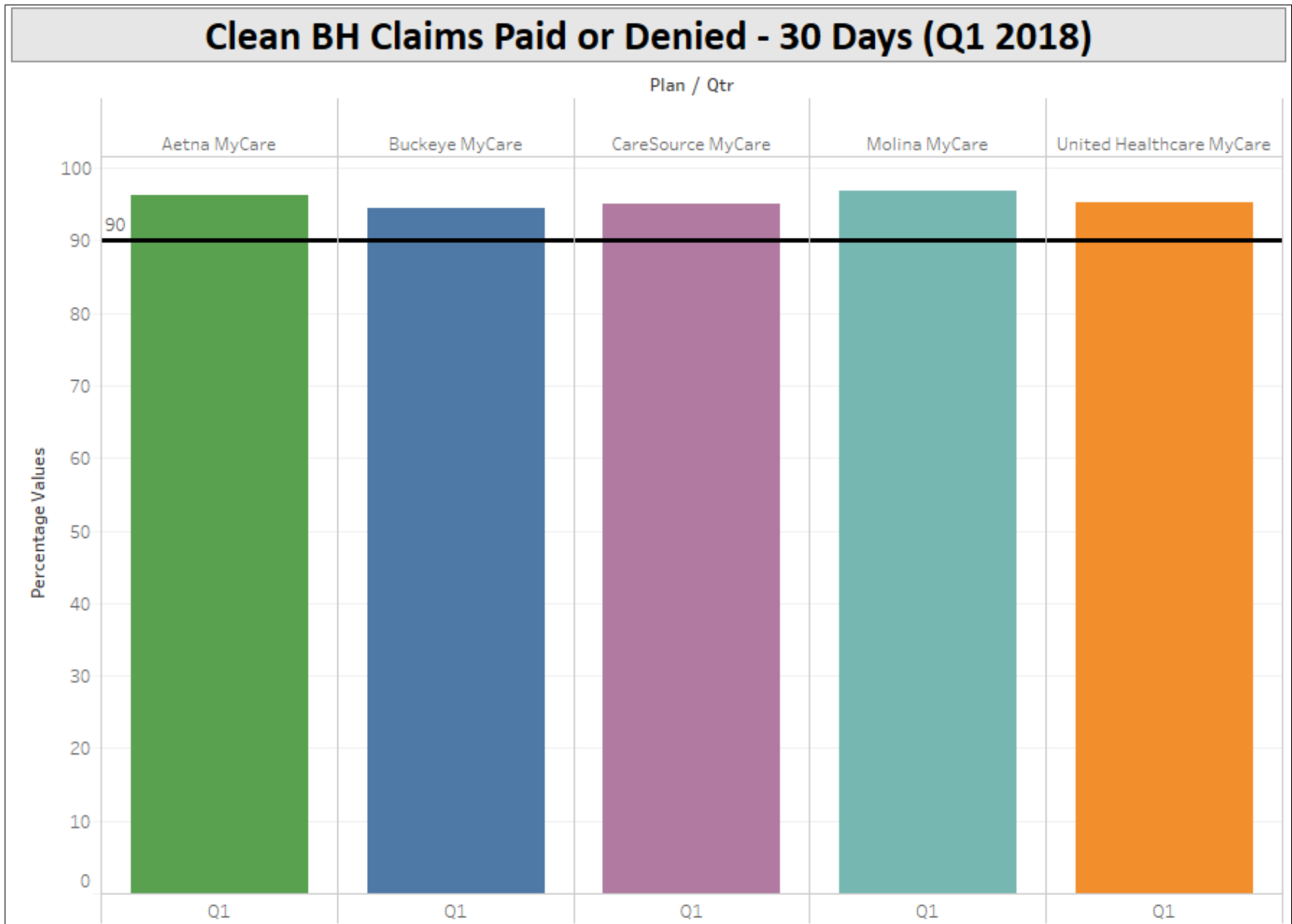
Note: Q1 2018 data is preliminary
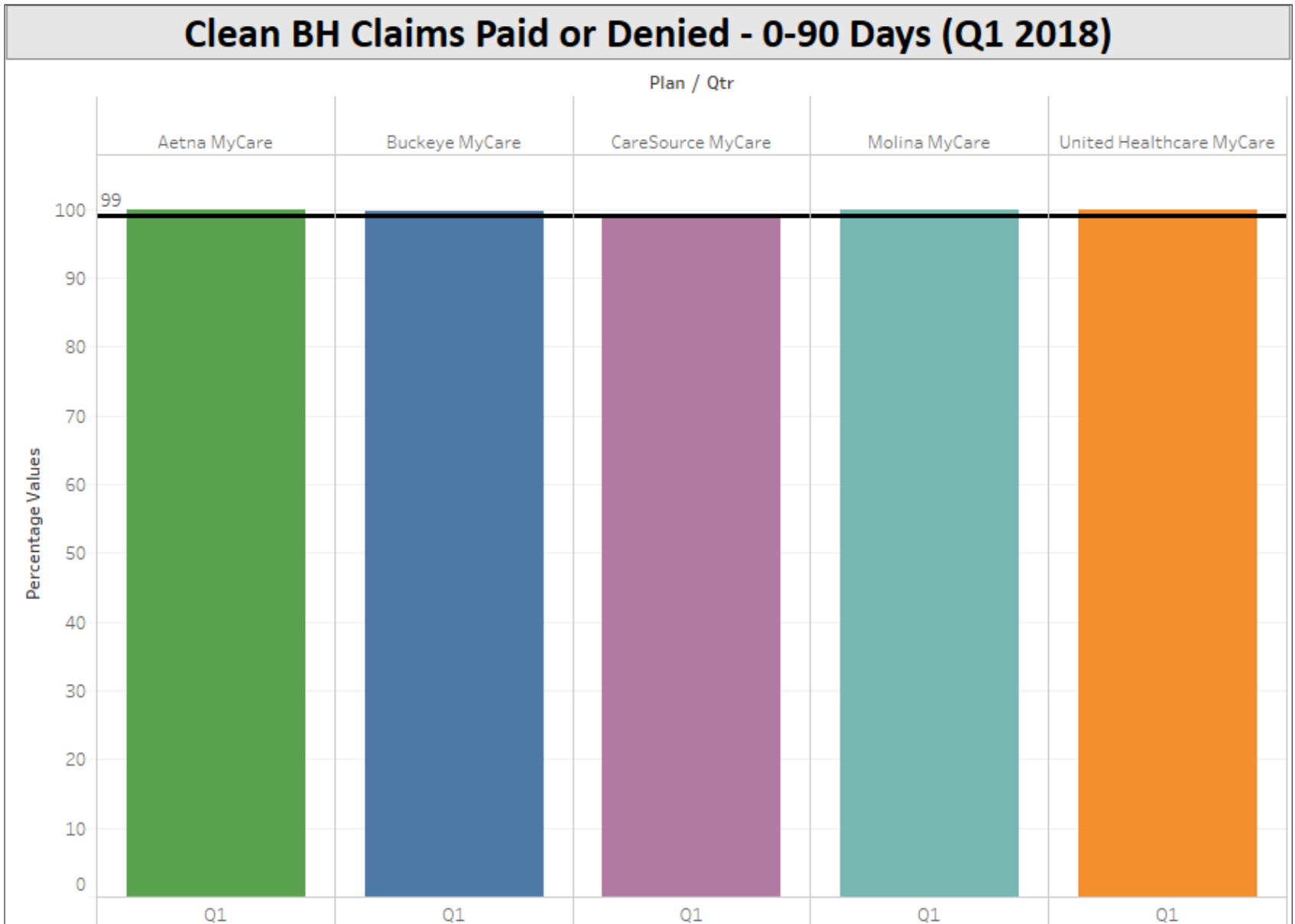
Note: Q1 2018 data is preliminary

Claim denial rates and provider error

As illustrated in prompt pay graphs, the MCPs are adjudicating and paying claims timely and effectively. Denials occur due to provider error. Most common reasons include:

- Duplicate claim
- Service not payable as billed
- Third party liability

MyCare Ohio BH line items denied based on original line items submitted by providers

Period	Original Line Items	Compliance Edits	Allowable Line Items	Paid	Denied	Denied Rate
January	9,999	-	9,999	6,961	3,038	30%
February	25,111	-	25,111	19,196	5,915	24%
March	45,983	-	45,983	34,913	11,070	24%
April	45,676	-	45,676	35,749	9,927	22%
4 Month Total	**126,769**	**-**	**126,769**	**96,819**	**29,950**	**24%**

SOURCE: MyCare Ohio Plans (May 2018).

The new system pays more accurately

MyCare BH line items after compliance edits to remove inappropriate submissions

Period	Original Line Items	Compliance Edits	Allowable Line Items	Paid	Denied	Denied Rate
January	9,999	444	9,555	6,961	2,594	27%
February	25,111	921	24,190	19,196	4,994	21%
March	45,983	3,392	42,591	34,913	7,678	18%
April	45,676	3,095	42,581	35,749	6,832	16%
4 Month Total	**126,769**	**7,852**	**118,917**	**96,819**	**22,098**	**19%**

- The old system identified duplicate claims – but the new system can also identify non-Medicaid claims, third-party liability, and outdated codes that are no longer in use

- **These line items –** *which providers should not have submitted* **– can now be removed during a compliance edit <u>prior to</u> consideration for payment**

SOURCE: MyCare Ohio Plans (May 2018).

The new system pays more accurately

MyCare Ohio BH line items after compliance edits and removing high-denied providers

Period	Original Line Items	Compliance Edits	Allowable Line Items	Paid	Denied	Denied Rate
January	9,999	3,464	6,535	5,416	1,119	17%
February	25,111	8,971	16,140	13,150	2,990	19%
March	45,983	17,557	28,426	24,263	4,163	15%
April	45,676	14,580	31,096	26,147	4,949	16%
4 Month Total	**126,769**	**44,571**	**82,198**	**68,976**	**13,222**	**16%**

- In addition, 8 providers account for the most (38%) denied line items
- **When these outliers are removed, the overall denial rate drops to 16%**

The plans have conducted extensive stakeholder engagement

- Systems have been available for two rounds of providing testing: prior to January 1; and systems are currently open for testing

- Issue policy clarifications through provider alerts

- Hosted 8 winter regional provider forums, and additional 8 regional forums are scheduled beginning May 21

- Rapid response teams have contacted providers who have a high number of denials and offered one on one education and assistance

- Continue to provide webinars, testing opportunities, and consultations for providers

- Credentialing teams are prioritizing applications for BH providers in advance of the carve-in

Contracting Requirements

Network Adequacy Standard Progress

Managed Care Plan	No. of counties meeting the network standard for contracted provider locations		Percent of counties meeting the network standard for contracted provider locations	
	MH	SUD	MH	SUD
Buckeye Health Plan	64	69	73%	78%
CareSource	82	70	93%	80%
Molina	83	80	94%	91%
Paramount	80	75	91%	85%
United Healthcare	81	74	92%	84%

SOURCE: Managed Care Plans (May 2018).

Contracted Locations

SOURCE: Managed Care Plans (May 2018).
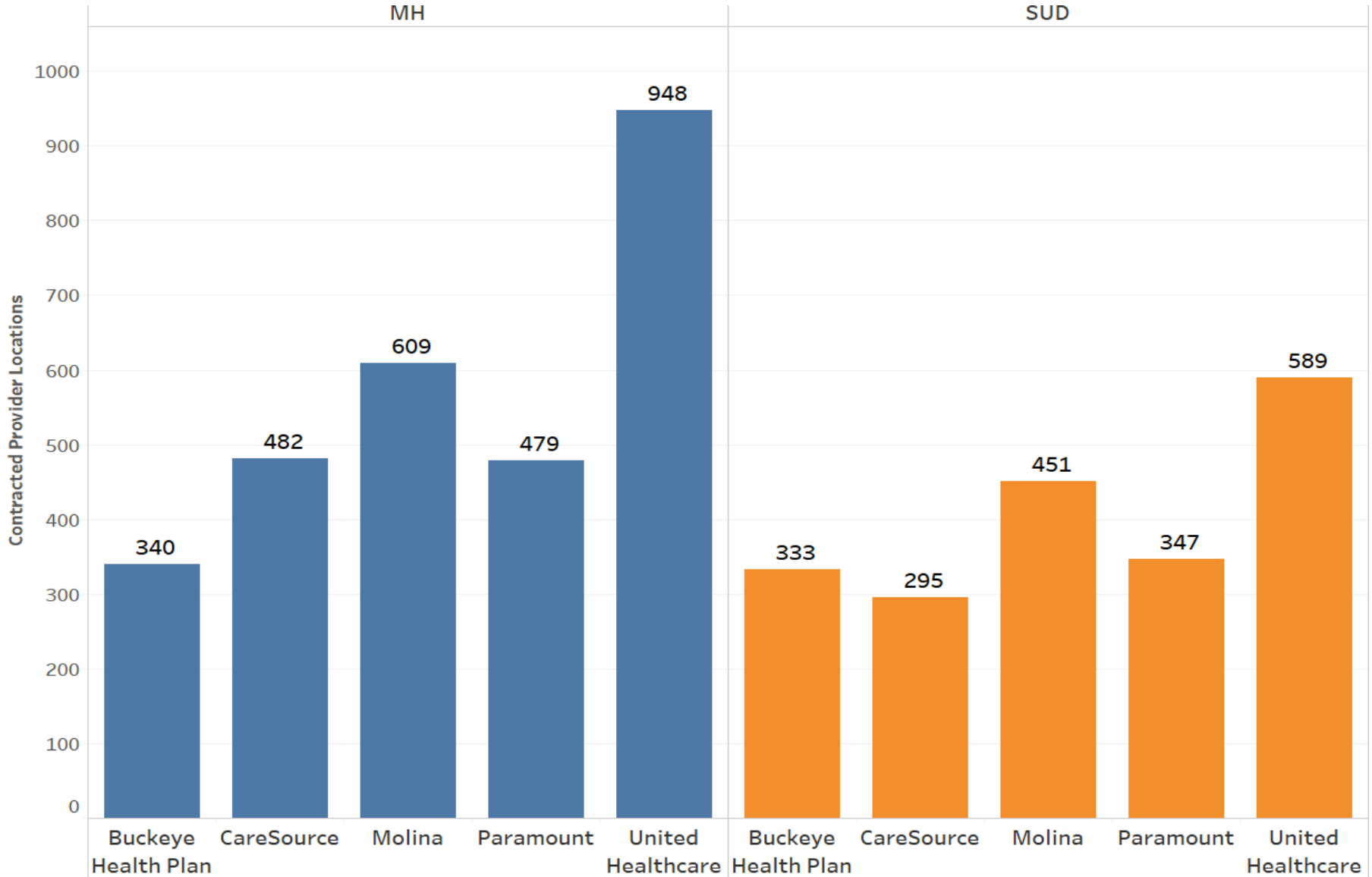
Safeguards Post Implementation

- Safeguards will be 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
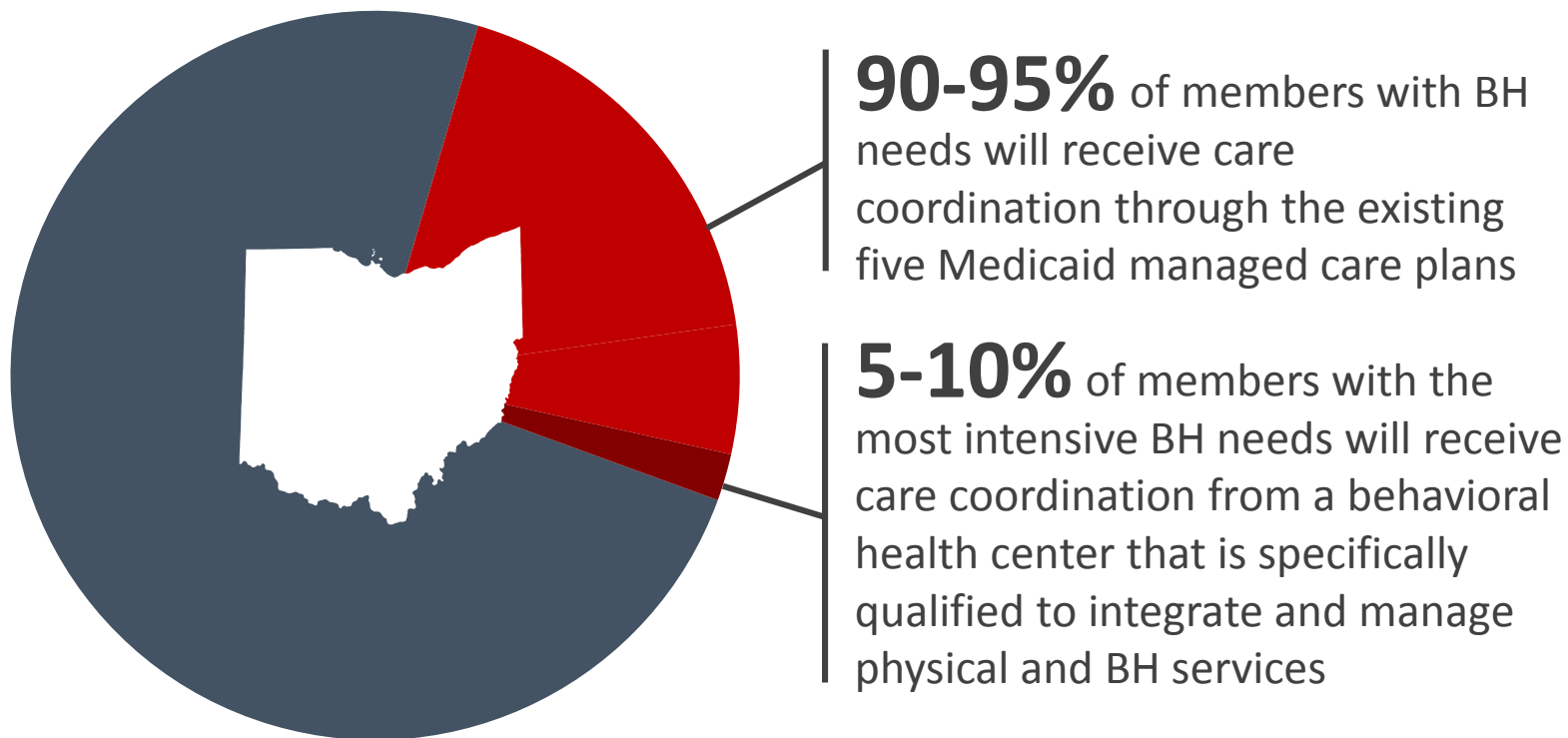
Safeguards Post Implementation

- Ohio Medicaid is committing to a post implementation **Task Force** to include the MCPs, providers, OACBHA and the Ohio Council

  » Meetings will be re-occurring in nature and be used to identify unanticipated issues as a collective – and address them quickly.

- Ohio Medicaid is also committing to a **Managed Care Contingency Plan** for interested providers similar in nature to what was established in fee for service in January.

  » This approach requires the plans to make a monthly payment for July, August, September and October to providers serving their members. Payments would be equal to 54.6 percent of the provider's average monthly Medicaid reimbursement in calendar year 2016

What Does it All Mean?

- Readiness Reviews will be complete tomorrow, at which point we expect to move forward with managed care integration on July 1, 2018.

- Over the next two months, ODM in conjunction with the managed care plans will continue extensive outreach to providers to help prepare for integration.

- ODM will also continue shaping the new Behavioral Health Care Coordination Model as noted in the last JMOC session and the next two slides.

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

Medicaid Managed Care Plan

- 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

Qualified Behavioral Health Center

Comprehensive Primary Care (CPC)
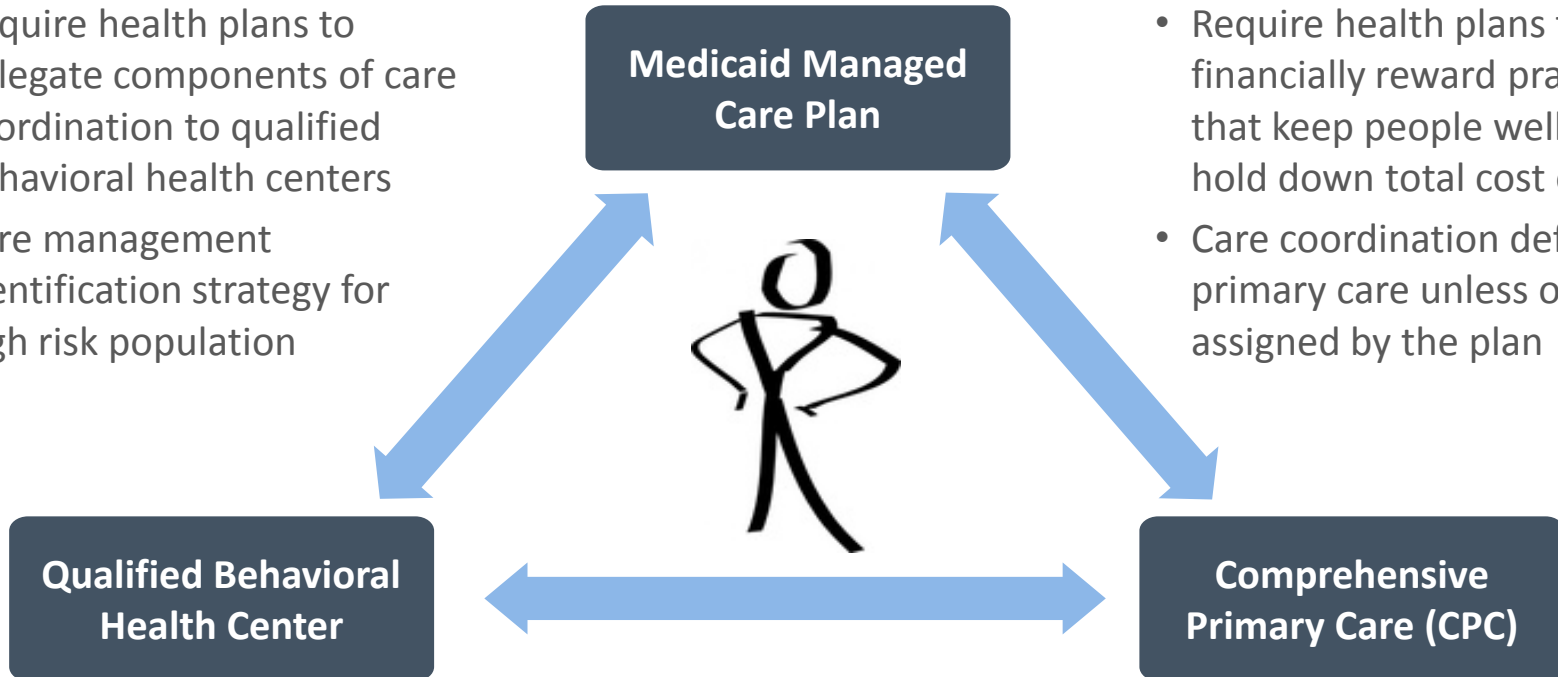
- Mutual accountability
- Alignment on care plan, member relationship, transitions of care, etc.
- Common identification of needs and assignment of care coordination

TODAY'S AGENDA

- Ohio Medicaid Budget
- BH Redesign – impact of 1/1 coding changes
- BH Redesign – readiness for 7/1 integration
- **Discussion**