Ohio | Department of Medicaid

Next Generation of Ohio Medicaid: July 1st & Staggered Implementation

Presentation to the Joint Medicaid Oversight Committee
May 19, 2022

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Agenda

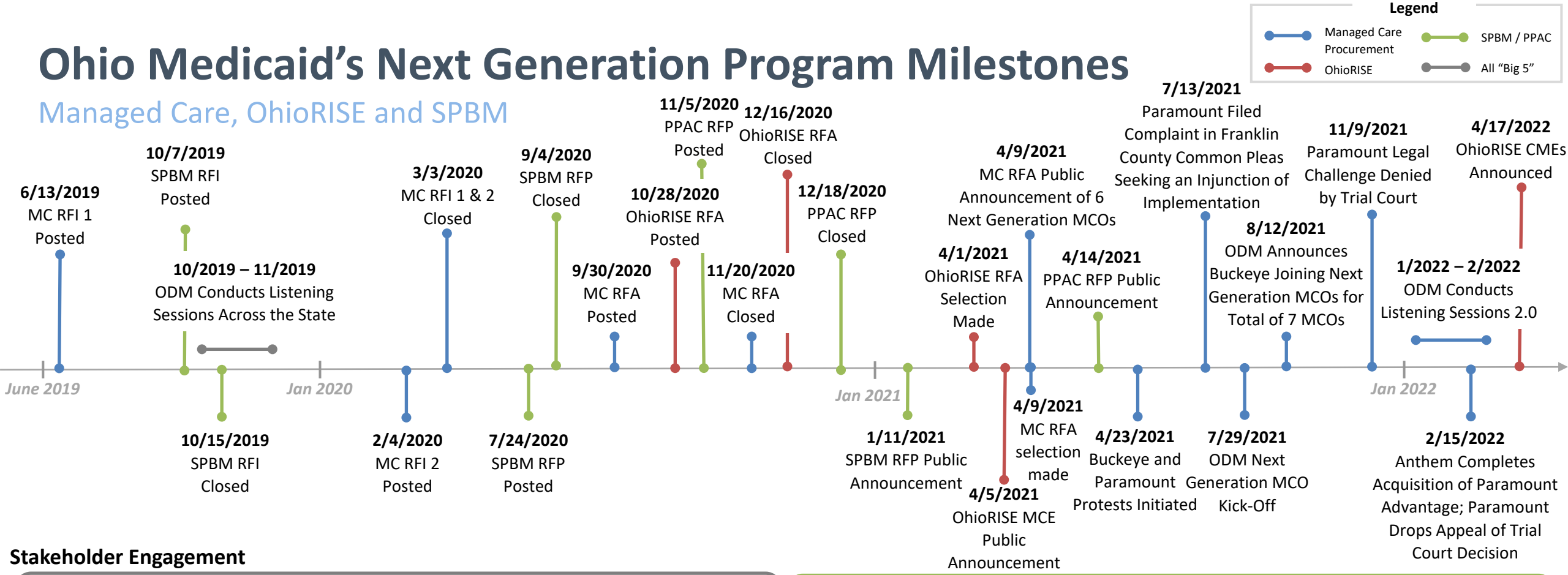
Next Generation Ohio Medicaid Staggered Implementation

- Next Generation: Status Update
- July 1 Launch & Staggered Implementation
- What this means for Members and Providers
- Next Generation Components Path to Launch
- Questions

Next Generation: Status Update

Ohio Medicaid's Next Generation Program Milestones

Managed Care, OhioRISE and SPBM



Stakeholder Engagement

All "Big 5" Strategic Initiatives
10/2019 – 11/2019
ODM Conducts 17 Listening Sessions Across the State with 119 Medicaid Members and 36 Community Partner Organizations Participating

SPBM / PPAC
10/7/2019 – 9/4/2020
RFI Open for Solicitation; ODM Received 19 Pieces of Feedback

Managed Care Procurement
6/13/2019 – 3/3/2020
RFI's Open for Solicitation; ODM Received over 1,000 Pieces of Feedback from Providers, Members, and Advocates

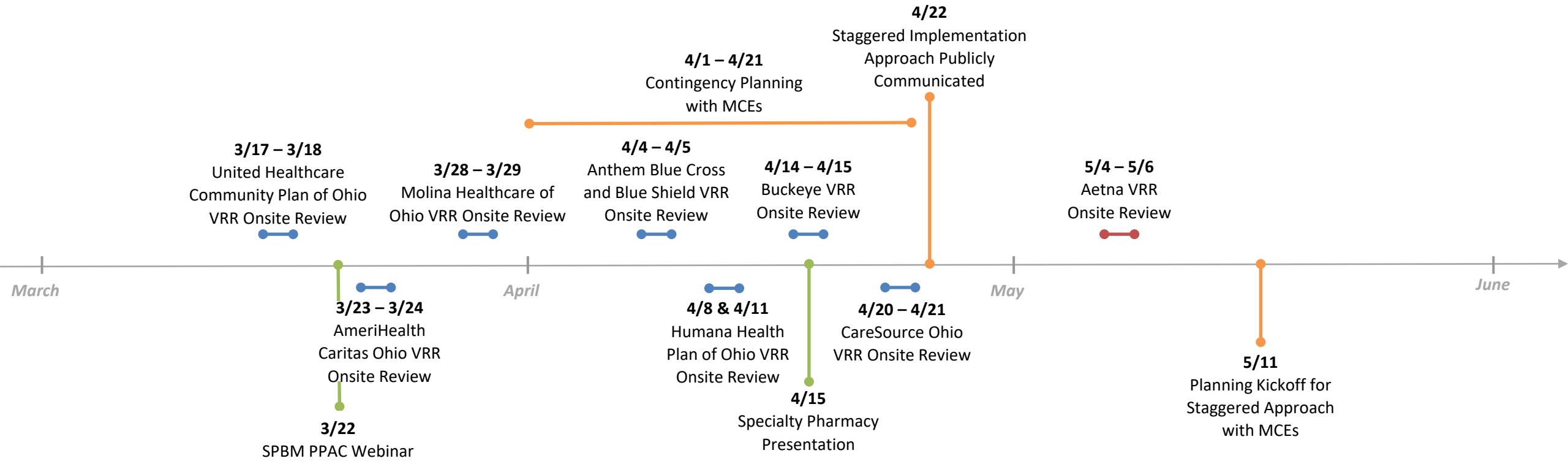
1/2022 – 2/2022
ODM Conducts 12 Listening Sessions with 56 Community Organizations Participating

OhioRISE
1/2021 – 3/2022
ODM Hosted 45 OhioRISE Advisory Council and Workgroup Meetings with 100-160+ Attendees

5/2021 – 1/2022
ODM Hosted 35 OhioRISE Roadshow Presentations to Local/Public Service Entities & Associations, Provider Associations, and Consumer Advocacy Organizations

2022 Next Generation Program Milestones | Progress To-Date

Ohio Medicaid's Next Generation Program



Legend

- Next Generation Managed Care
- SPBM / PPAC
- Staggered Implementation Approach
- OhioRISE

Additional Next Generation Program Updates

SPBM / PPAC

Completing system build, finalizing clinical / operational policies and procedures, and contracting with pharmacy providers. Finalizing pharmacy pricing / reimbursement methodology.

Managed Care

Development complete for transition and enrollment plan for next generation managed care plans. Update completed.

Onsite reviews completed.

Centralized Credentialing

Established the Credentials Verification Organization and Credentialing Committee. Began testing including Sister State agencies and MCEs.

Fiscal Intermediary

Completed initial design and system configuration; preparing for end-to-end system integration testing and user acceptance testing.

Managed Care Provider Agreement Changes: Themes

Next Generation of Ohio Medicaid's Managed Care Provider Agreement

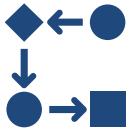
The next generation provider agreement includes a variety of changes to focus on the individual rather than the business of managed care

Improvement in Member Access to Services

Increasing timeliness and access to information and services (e.g., telehealth)

Care Management & Coordination

Strengthening requirements to emphasize disparity reduction and health efforts (e.g., implementation of high-performing care coordination program and health navigators)



Greater Consistency/ Processes for Providers

Revising processes to increase timely and accurate notifications and ease administrative burden (e.g., standardization of MCO notification for authorization submission)

Enhanced Support for Member Transportation

Providing enhanced transportation service coordination and a dedicated call center selection with trained staff to support members (e.g., member services call center and MCE provided transportation over 30 miles from member's home)

Increased Program Transparency & Enhanced Accountability

Increasing transparency and access to data along with accountability of quality improvement projects (e.g., ODM remote connectivity to all data relevant to care provided to members)

Operating Agreements for All MCEs

Establishing improved payment and communications timelines in all MCE operating agreements (e.g., coordination between MCEs, OhioRISE, and the SPBM to develop written agreements)

Population Health

Employing population health management principles to address health inequities and disparities to achieve optimal population outcomes (e.g., MCEs identify disparities, partner with community based organizations, and follow-up on needs)

Community Based Engagement

Demonstrating a commitment to improving health outcomes in local communities through community reinvestment activities (e.g., MCE contribution of its annual after-tax profits to community reinvestment)

July 1 Launch & Staggered Implementation

Path-to-Launch Plan Summary

Staggered Implementation Approach | Next Generation of Ohio Medicaid

Context

- **Testing**
- **MCO Readiness & Provider Training**
- **Unwinding the PHE:**
- If the end of PHE is 10/13, states would likely receive 60 day notice no later than 8/14 & begin unwinding

Goals

- Our first priority is our members and the providers supporting their care
- Eligible members will continue to receive the full complement of Medicaid benefits available today
- Providers will experience a smooth seamless transition, with time to test and adapt operations
- MCOs, PBM, OhioRISE and ODM are committed to a collaborative, successful and sustainable implementation.

Path-to-Launch Plan Summary

Staggered Implementation Approach | Next Generation of Ohio Medicaid

Next Generation Go-Live begins on July 1, 2022 with the implementation of OhioRISE

MCE Rollout / Roadmap

- **Stage 1:** OhioRISE live on July 1, 2022 to meet immediate needs of children and families.
- **Stage 2:** Centralized Provider Credentialing goes live October 2022 to lessen the administrative burden on providers and increase time available to deliver services to members.
- **Stage 2:** Single Pharmacy Benefit Manager (SPBM) goes live in October 2022 to provide a transparent single pharmacy service and network across all plans and members.
- **Stage 3:** Implement the Next Gen MCOs and complete the OMES implementation in 4th quarter 2022 to fulfill the vision.

MCO Next Gen Implementation

- **Currently Operating NextGen Plans**
  - Need to continue existing processes:
    - Pharmacy benefit management
    - Provider credentialing
    - Call center operations
    - Receipt and adjudication of claims & prior authorizations
  - Continue vendor readiness processes
  - Continue OMES implementation, but use legacy/MITS for the staggered start
  - All EDI/data sharing remains as-is with the exception of Member Enrollment (834) with OhioRISE information (minimal change).
- **New NextGen Plans**
  - Continue OMES implementation
  - Continue vendor readiness processes: staff hiring and building provider network.

Focus on the Individual
Members: Honor choice. Provide continuity of care. Manage change with no impact on members. **Providers:** Reduce the burden & complexity. Support care to members. Manage the change with no impact to providers. **Competitive, sustainable marketplace, capable of needed innovation & sustainability.**

Stage 1: OhioRISE Launches July 1, 2022

OhioRISE Priorities

Kids get enrolled and get the care they need

Providers are appropriately reimbursed

Partners work together to build local systems of care for Ohio kids

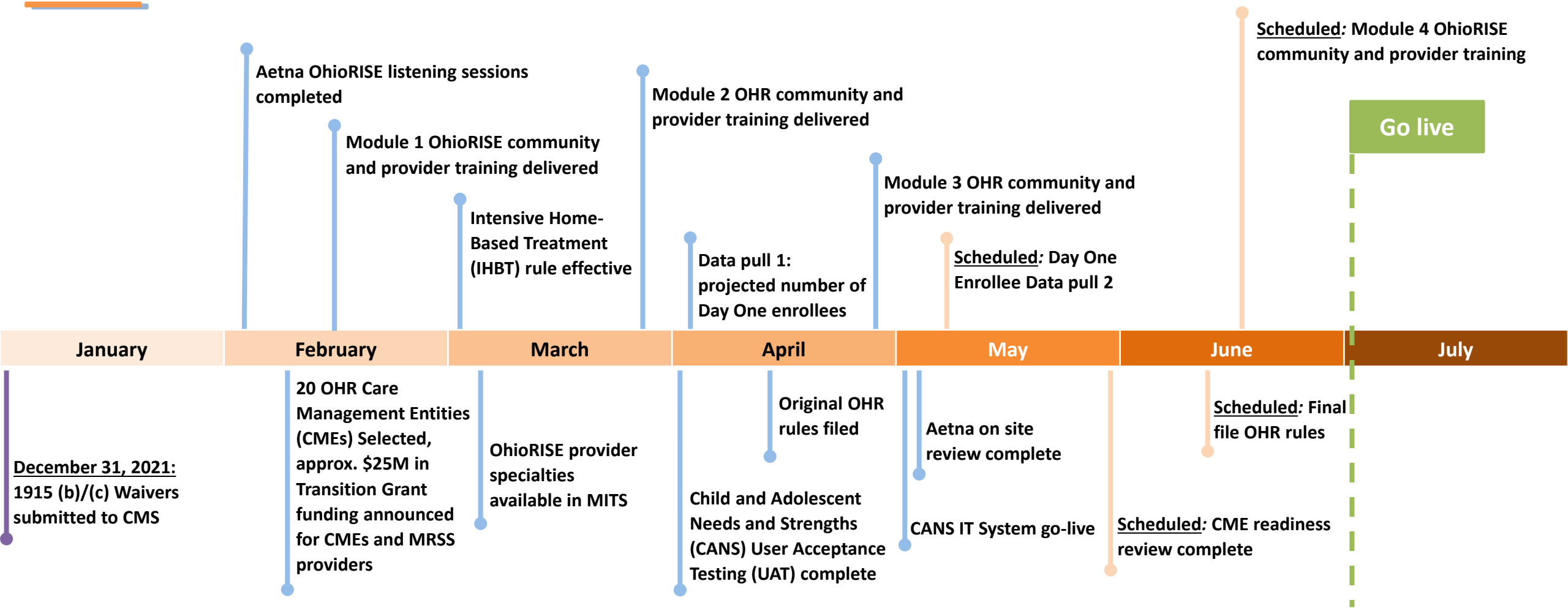
Carefully transition services and integrate care across MCOs and OhioRISE Plan

- Integration based on >1 year of work among MCOs and OhioRISE Plan to assure care is seamless, data is shared, all transitions are handled with care
- Children and youth in OhioRISE maintain their physical health and pharmacy coverage through their managed care organization or fee-for-service Medicaid; behavioral health care is covered by OhioRISE

Begin New OhioRISE Care on 7/1/22

- Some kids will be automatically enrolled on 7/1/22 based on history of significant BH treatment, other children and youth will enroll into the program on every day thereafter
- Kids start to receive new and improved OhioRISE services: Intensive and moderate care coordination from regional Care Management Entities (CMEs), Intensive Home-Based Treatment, Mobile Response and stabilization Services, Behavioral Health Respite, etc.
- OhioRISE 1915(c) waiver will become effective to help prevent custody relinquishment
- Work toward program goals: improve BH outcomes and family satisfaction, reduce out of home and out of state placements, reduce moves between foster homes, reduce juvenile justice recidivism

What OhioRISE milestones have we accomplished this year?



Advisory Council meetings, Implementation and Operations (I&O) Workgroup meetings, CANS/CANS IT System trainings, training tracks for specific OhioRISE stakeholders

Supporting and expanding Mobile Response and Stabilization Services (MRSS) providers

What this means for Members and Providers

What This Means for Ohio Medicaid Members

Staggered Implementation Approach | Next Generation of Ohio Medicaid

Honor Choice

Members who do not want to change their current plan do not need to do anything and will remain with their managed care plan. Members contact the Medicaid Consumer Hotline to change their plan / select a Next Generation managed care plan at any time between now and November 30, 2022.

Provide Continuity of Care

Ohio Medicaid members will not lose healthcare coverage or benefits due to the Next Generation program implementation. Members will continue receiving the same services they do today from the same providers.

Manage Change with Least Confusion for Members

The staggered go live of the Next Generation program allows for testing & structural changes to occur without involving the member. It also allows the state, members, providers and plans to monitor and adjust to the impact of the PHE to reduce confusion and uncertainty.

What This Means for Ohio Medicaid Providers

Staggered Implementation Approach | Next Generation of Ohio Medicaid

Reduce the Burden & Complexity

In preparation for the transition to Centralized Credentialing in October 2022 and streamlining the process for claims and prior authorization submissions later in the year, ODM will send communications and provide trainings to inform and support providers, provider associations, and trading partners in understanding the changes they will experience.

Support Care to Members

The staggered implementation of the Next Generation program will not result in changes or terminations to providers' current MCO contracts. It also allows the state, members, providers and plans to monitor and adjust to the impact of the PHE to reduce confusion and uncertainty.

Manage Change with Least Disruption to Providers

OhioRISE changes will occur first, with centralized credentialling and SPBM second. The staggered go live of the Next Generation program allows additional time for provider testing, education and practice changes to occur.

Stage 2: Single Pharmacy Benefit Manager (SPBM)
&
Centralized Provider Credentialling
Launch

SPBM Path-to-Launch Plan

gainwell

Single Pharmacy Benefit Manager (SPBM) will go live in October 2022

- SPBM manages contracts with all network pharmacies
- SPBM connects and exchanges information with all network pharmacies for all claims processing functions and features, e.g., member eligibility, Preferred Drug List (PDL), pricing information, claims submission
- SPBM Contact Center/Help Desk accepting calls from pharmacy providers for contracting questions
- Coordination of Care supported as planned
- **MCOs operate individual PBMs through September 30, 2022**

SPBM Milestones

- Held two stakeholder webinars. Third webinar is coming soon re: reimbursement methodology/dispensing fees
- Gainwell began network contracting process on March 29
- OAAC survey complete, significant majority of pharmacies responded
  - » Closed on April 30th
- Launched SPBM website: https://spbm.medicaid.ohio.gov
- Testing plan includes pharmacy providers
- Gainwell is working with MCOs to ensure coordination in member care and operations between health plans
- Learning from CA Medicaid implementation by engaging with experts from the industry to mitigate impacts to members and providers on Day 1

PNM Path-to-Launch Plan

MAXIMUS

Centralized Provider Credentialing will go live in October 2022

- All applications, enrollment and credentialing occurs through ODM PNM system
- Providers use PNM portal to update appropriate information, e.g., demographics, group affiliation
- Provider Master File and information updates to MCOs will occur through planned OMES service

Stage 3: Next Gen Plans & OMES Full Launch

Next Gen Plans & Full OMES Launch

Next Gen MCOs and Program Implementation & Complete the OMES implementation

- Implementation of the Fiscal Intermediary as the central clearinghouse for all provider claims and PA requests completes the OMES infrastructure
- Transition to the Next Gen MCO contracts and full integration of the MCOs, SPBM, and OhioRISE in member care
- Humana, AmeriHealth, and Anthem (Central/SE) begin to provide services

Path-to-Launch Plan Recap

Staggered Implementation Approach | Next Generation of Ohio Medicaid

Next Generation Go-Live begins on July 1, 2022 with the implementation of OhioRISE

MCE Rollout / Roadmap

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Questions?

Appendix

Ohio | Department of Medicaid

The following slides were taken from the 4/7/22 presentation to JMOC

Ohio Medicaid: Preparing for the State's Unwinding Efforts

Components of 12 month Unwinding Plan

- Forward date overdue renewals to the individual's anniversary month.
- Each month ODM will run ex parte process on past-due and pending renewals.
  - » If ex parte renewal is successful, notify the individual of renewal
  - » If ex parte renewal not successful, begin manual renewal process and provide "fallouts" to data analytics vendor to test "likeliness of ineligibility", likely eligible or fraud.
- Each month CDJFS:
  - » Caseworker can use data from likely eligible to conduct administrative ex parte renewal
  - » If likely **in**eligible (based on vendor findings or individual previously found ineligible), caseworker will process those as priority cases (request individual's info; use PCG info as lead, but **must verify** in order to terminate)
  - » Maintain timely processing of new applications & redeterminations
- Data cannot be older than 3 months to be actionable.

Federal Guidance

- CMS has issued multiple guidance documents since the beginning of the PHE in an effort to guide states through the unwinding:
  - » December 22, 2020 (click the link to access)
  - » August 13, 2021 (click the link to access)
  - » March 3, 2022 (click the link to access)
  - » *April 7, 2022 Letter from D. Tsai, CMS to Ohio (CMS Ohio Unwinding Compliance Letter 04/07/2022)
  - » *May 10, 2022 Letter to Governors, Secretary Becerra and CMS Administrator Brooks-Lasure (Letter to Governors on Unwinding 05/10/2022)
  - » *May 17, 2022, CMS Eligibility Enrollment Processing for Public Health Emergency Unwinding 5-12-2022 Key requirements for compliance.
- ODM is currently still working through the latest iteration of guidance to ensure compliance, feasibility and compatibility with other legislative requirements
- CMS Corrective Action Plan: 2019 Application backlog
- CMS Corrective Action Plan: 2019 PERM audit, inc. past due renewals

*Updated

HB 110 & Reconciling with Federal Guidance: Emphasis on areas of potential conflict

HB 110: 5163.52 & Section 333.255

• Vendor must assist ODM in identifying those enrolled in Medicaid who are deemed to be “likely ineligible” to prioritize those case when PHE ends and • Complete them within 90 days	• Data analytics vendor in place; will assist in identifying individuals who are "likely ineligible" • ODM and contractor are completing system set ups now including data sharing agreements with relevant agencies and non-state entities • ODM and the counties will prioritize the processing of those deemed “likely ineligible" • States cannot make an eligibility determination if the data being used is more than 3 months old
• ODM must conduct an expedited eligibility of newly enrolled for 3 or more months during PHE but not in the last 6 months. This must be done within six months after the PHE ends. • Request approval from CMS to conduct redeterminations on recipients enrolled for more than 3 months and act on those redeterminations within 90 days. Individual counties can request an additional 30 days	• Data analytics vendor will help identify those "most likely to be ineligible" • As required, ODM made this request to CMS. However, per 42 CFR 435.916 and reiterated in CMS’ unwinding guidance, states are not permitted to do eligibility renewals on an individual more than once every 12 months. • Per CMS guidance, states may not redetermine more than 1/9 of their total Medicaid caseload each month. • States cannot make an eligibility determination if the data being used is more than 3 months old • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two Corrective Action Plans.
• Completes and acts on redeterminations within 60 days of all individuals who haven’t had a redetermination in 12 months	• Per CMS guidance, states may not redetermine more than 1/9 of their membership every month. • States cannot make an eligibility determination if the data being used is more than 3 months old • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two Corrective Action Plans.

Emphasis on areas of potential conflict between state and federal law. See next two slides for complete analysis.

HB 110 Implementation Efforts: Section 333.255

Seek Controlling Board approval for a 3rd party vendor by November 1st, 2021 (A)	Completed on time. Received CB approval on 10/25/21.
Vendor must have access to 8 different types of records to assist in verifying eligibility (B)	The contracted vendor will have access to these data sources.
Vendor must assist ODM in identifying those enrolled in Medicaid who are deemed to be “likely ineligible” to prioritize those case when PHE ends and complete them within 90 days (C)	• Data analytics vendor is in place; will assist in identifying individuals who are "likely ineligible". • ODM and the counties will prioritize the processing of those deemed to be “likely ineligible” while complying with federal requirements. • States cannot make an eligibility determination if the data being used is more than 3 months old.
ODM must conduct an expedited eligibility of newly enrolled for 3 or more months during PHE but not in the last 6 months. This must be done within **six months** after the PHE ends (D)	• Data analytics vendor will help identify those "most likely to be ineligible" • As required, ODM made this request to CMS. However, per 42 CFR 435.916 and reiterated in CMS’ unwinding guidance, states are not permitted to do eligibility renewals on an individual more than once every 12 months. • Per CMS guidance, states may not redetermine more than 1/9 of their total Medicaid caseload each month. • States cannot make an eligibility determination if the data being used is more than 3 months old. • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two federal Corrective Action Plans.
ODM must write a report of its findings from working with the 3rd party vendor and submit it to certain public officials no later than 120 days after the PHE ends. (E)	ODM will complete the required report.
The 3rd party vendor must be reimbursed entirely based on validated cost savings realized by the department. (F)	Reimbursement/vendor contract with ODM is compliant with the statutory requirement.

HB 110 Implementation Efforts: Section 5163.52

ODM must continue to conduct eligibility redeterminations to the fullest extent permitted under the law. (A)	The counties have continued to perform redeterminations and renewals throughout the PHE. However, because of the requirement to maintain eligibility, states are unable to disenroll, except in limited circumstances.
Within 60 days of the end of the PHE, ODM must complete an audit (B)	ODM has or will comply with the requirements for the audit.
Completes and acts on redeterminations within 60 days of all individuals who haven't had a redetermination in 12 months (B)(1)	• This conflicts with the 6-month timeline in 333.255(D). • Per CMS guidance, states may not redetermine more than 1/9 of their membership every month. • States cannot make an eligibility determination if the data being used is more than 3 months old • PCG data analytics will help identify those who are "most likely to be ineligible". Prioritization of these cases by the county will enable us to right-size the Medicaid caseload. • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two federal Corrective Action Plans.
Requests approval from CMS to conduct redeterminations on recipients enrolled for more than 3 months and act on those redeterminations within 90 days. Individual counties can request an additional 30 days (B)(2)	• As required, ODM made this request to CMS. However, per 42 CFR 435.916 and reiterated in CMS' unwinding guidance, states are not permitted to do eligibility renewals on an individual more than once every 12 months. • Per CMS guidance, states may not redetermine more than 1/9 of their total Medicaid caseload each month. • States cannot make an eligibility determination if the data being used is more than 3 months old • Data analytics vendor will help identify those "most likely to be ineligible" • Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two Corrective Action Plans.
Submit a report summarizing the results of the audit to certain public officials (B)(3)	ODM will submit the required report.

ODM Member Assignment Strategies

Assignment Name	Description
Member Assignment Strategies	To ensure a member-first perspective and Medicaid system stability, ODM will utilize four levers for member assignments to the Next Generation MCOs: 1. Member Choice 2. Supporting Continuity of Care/Providers of Care 3. Household Continuity 4. MCO Weighted Assignments ***Next Generation MCO viability will be assessed and evaluated routinely to determine when member assignment strategies will be adjusted***
1. Member Choice	• Member choice will be honored. • All members will be encouraged through a comprehensive, ODM-led communications and outreach campaign to actively select a Next Generation MCO that best meets their healthcare needs. • *Transfer: in the event that a small number of members are transferred to another plan, the member will have a choice to change their assignment and select another plan. At any time a member makes a choice they would not be considered in any consideration of transfer.*
2. Supporting Continuity of Care	The provider network supporting member's continuity of care will be maintained. Current members, and returning applicants, will be placed with plans that can support their known provider experience subject to a member's choice. **Beginning 5 months post go-live, pending outcome of assessment period.**
3. Household Continuity	Next Generation MCO assignments will be based on a common provider network for the member and among the household. The impact on member continuity of care will be minimized through this provider network review.
4. MCO Weighted Assignments	Remaining members newly eligible for Medicaid managed care will be assigned to a Next Generation MCO based on 4 phases. • Prior to go live: 100% to new/hybrid MCOs (FFS Pool) • 1-6 months post go-live: • 7-12 months post go-live: • 13-18 months post go-live: