Department of Medicaid

Appendix K Authorities and Rate Cap Construction

A presentation to the Joint Medicaid Oversight Committee

September 13, 2023

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Ohio's Response to the PHE

In March 2020, the ODM made operational changes to its Medicaid program in response to the COVID-19 **public health emergency** (PHE), including taking advantage of the flexibilities offered to states such as:

- Increasing service limits for Home-and Community-Based Waiver Services.
- Expanding telehealth.
- Adding Health Care Isolation Centers (HCICs) as a nursing facility benefit.

States had various tools to implement these flexibilities:

- Disaster Relief SPAs (13 filings)
- Section 1135 waivers (1 filing)
- Appendix K (10 filings)

Appendix K is a standalone authority that may be utilized by states during federally declared emergencies to allow flexibility with approved home and community based 1915(c) waivers.

Appendix K Basics and Content

Appendix K Authorities Modified and Continued

#k	Category	Description	Impacted Waivers	Post-PHE Status
1.	Enrollee Signatures	Add an electronic method of signing off on required documents such as the person-centered service plan.	**AL, OHC, PP, MC, IO, L1, SELF**	**CONTINUE**
2.	Remote Service Delivery	Add an electronic method of service delivery (e.g., telephonic) allowing services to continue remotely in the home setting for monthly monitoring.	**OHC, PP, MC**	**CONTINUE for NF-based**
3.	Service Delivery Notification	Service rule amendment to reflect that if individual signature requirement cannot be met at the time of service, the provider may accept an electronic signature or standard signature via regular mail from the individual, or otherwise obtain signature no later than at the next face-to-face visit with the individual.	**OHC, PP, MC**	**CONTINUE for NF-based**
4.	Family or Legally Responsible Individual	Parents as paid caregivers.	**IO, L1, SELF**	**MODIFY**
5.	Family or Legally Responsible Individual	Parents as paid caregivers.	**OHC, PP, MC**	**MODIFY**
6.	Remote Service Delivery	Add an electronic method of service delivery (e.g., telephonic) allowing services to continue remotely in the home setting, and others. See flexibility tracker for more.	**IO, L1, SELF**	**MODIFY**
7.	Homemaker/Personal Care in a Hospital Setting	Permit Homemaker/Personal Care to be provided to an individual in an acute care hospital. Increase payment rates effective January 1, 2024. Correct citations to Admin Code. Align wording with newer rules. Permit Participant-Directed Homemaker/Personal Care to be provided to an individual in an acute care hospital. Increase payment rates effective January 1, 2024. Correct citations to Admin code. Align wording with newer rules. Permit Residential Respite to be provided on the same day as Shared Living. Eliminate existing paragraph (D)(10) which permitted Homemaker/Personal Care to be provided on the same day as Shared Living during the COVID-19 state of emergency. Add new paragraph (D)(10) to permit Shared Living to be provided to an individual in an acute care hospital. Create additional exemptions that permit individuals who live with their caregivers (generally regarded as Shared Living) to receive Homemaker/Personal Care service instead of Shard Living. Increase payment rates effective January 1, 2024. Correct citations to Admin code. Align wording with new rules.	**IO, L1, SELF**	**MODIFY**

See Addendum for all of the PHE authorities that Ohio utilized.

Family Paid Caregiver: From PHE Authority to Permanent Rule

- Prior to the COVID-19 Public Health Emergency (PHE)
  - » Relatives of adults who not "legally responsible" were allowed to be paid for providing services. There is variability across all the NF & DD waivers regarding how this is designed.
  - » There was not an allowance for "legally responsible" care givers (parents of minor children and spouses) to be paid for providing services, with the exception of waiver nursing for Ohio Home Care Waiver.
- During the PHE, the State of Ohio permitted payment for direct services rendered to minor children by family caregivers or legally responsible guardians, including spouses. This requires being employed by an agency.
- The importance of paying family members is essential to augment the available workforce.

PHE Impact on Home- and Community-Based Services Waiver

Appendix K Flexibilities

- Ohio Departments of Medicaid (ODM), Aging (ODA), and Developmental Disabilities (DODD) have collaborated with stakeholders throughout the process of planning for the Appendix K authorities to end and are appreciative of the public's continued engagement and advocacy
- Ohio's authorities sunset six months after the expiration of the public health emergency, on November 12th, 2023
- On July 13th, Ohio posted the PASSPORT, Assisted Living, Ohio Home Care, MyCare, Individual Options, Level 1, and SELF waiver applications and associated Ohio Administrative Code (OAC) rules for public comment, in anticipation of an effective date of November 12th, 2023
- In early August, however, the Centers for Medicare & Medicaid Services (CMS) provided states with the option to extend approved flexibilities past the November 12th date, as long as the state is in the process of permanent amendments pending CMS review and approval
  - » As a result, effective dates on the proposed waiver application amendments and corresponding OAC rules will be modified to reflect a **new effective date of January 1st, 2024**
  - » The public comment timeframe was extended and a new public posting was issued with the updated applications
  - » Notification of the posting of the updated waiver applications will be shared with ODM's Home- and Community-Based Services listserv when they've been posted to Public Notices (ohio.gov)

Paying "Legally Responsible" Family Caregivers: Goals and Additional Requirements

A parent of a minor child or spouse (a.k.a. legally responsible family member) will continue to be permitted to serve as a direct care worker when the Appendix K expires.

- This helps to address direct caregiver provider shortages
  - ❖ However, the rule requires that no other provider is willing/able to provide care before a family caregiver can be reimbursed for services
- This ensures as much flexibility as possible in order to meet the needs of individuals enrolled in the waiver programs
- Reimbursing family caregivers reduces the likelihood of the individual requiring placement in a NF or ICF-IID
- There are additional CMS requirements and oversight required
- We hear from families that loved ones provide the best care and we want to provide our families with the best care possible to meet their needs

Please note, the State is making every effort throughout this process to align across ODM, ODA, and DODD and is working to have the same rule requirements wherever possible

Federal Requirements and Oversight for Paying Legally Responsible Family Members

- Ohio is proposing rule changes to make these Appendix K flexibilities permanent, but must be compliant with federal regulations
- CMS requires state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by legally responsible individuals
  - » To document that the care is outside of that care that would 'normally' be expected of the care giver. Example: parent feeding a 2 y.o. versus feeding a 16 y.o.
- Additionally, the State is proposing different parameters for a parent of a minor child or spouse (legally responsible individual) and relatives
  - » However, CMS is requiring that the new rules provide more specificity than blanket allowances for all parents of minor children

See CMS guidance for Leveraging Family Caregivers for Personal Care Waiver Services in 1915(c) Waiver Programs, page 19

Two Other Pandemic Authorities that are being revised and continued—

Remote Service Delivery & Direct Support/Care (HPC)* in During a Hospital Stay & Residential Respite

- Original authorities were very broad and very general
- Changes are intended to provide protections for the beneficiary
- Changes provide service limits and expectations on delivery of HPC service
- Changes place restriction on delivering residential respite at the same time as shared living

**These apply to the DODD waivers only.*

Capitation and Rate Setting Process

Capitation & Rate Setting: Setting the Stage

- The basics
- Topics for today's discussion

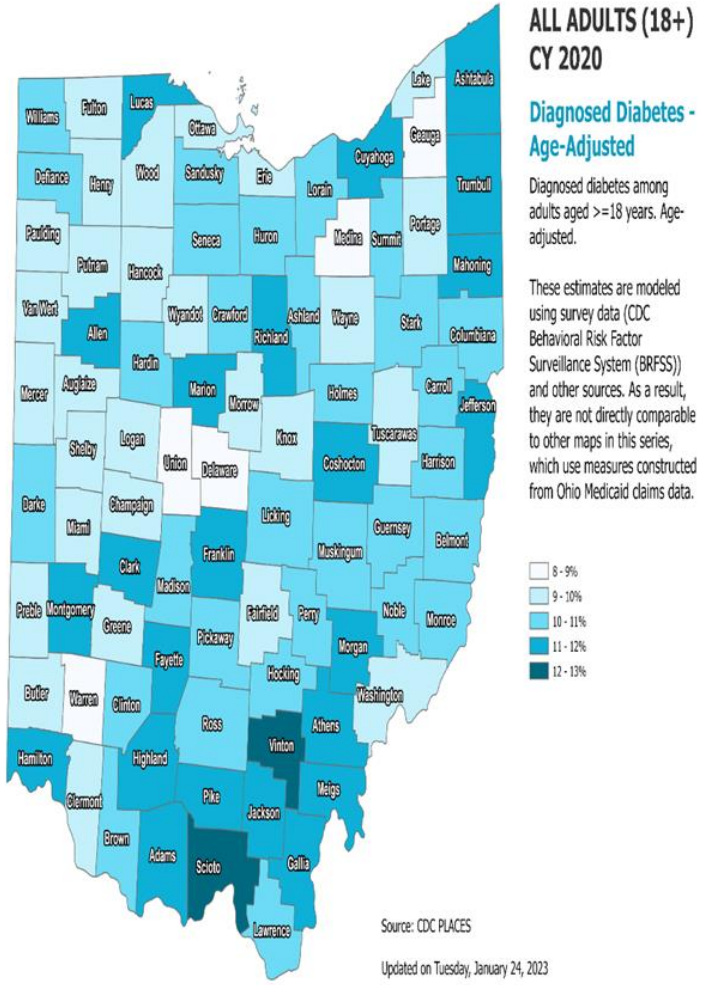
Rate Construction Maximizes Quality and Constrains Administrative Spending

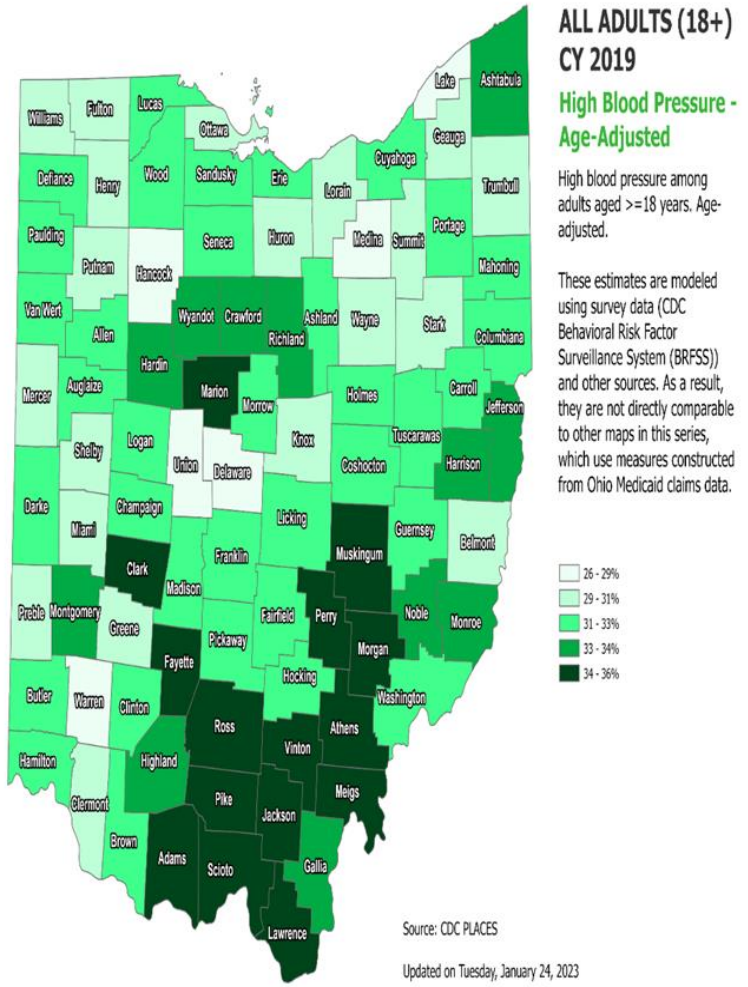
The rate setting process creates downward pressure to maintain appropriate administrative spend and maximize incentives to invest in greater care management

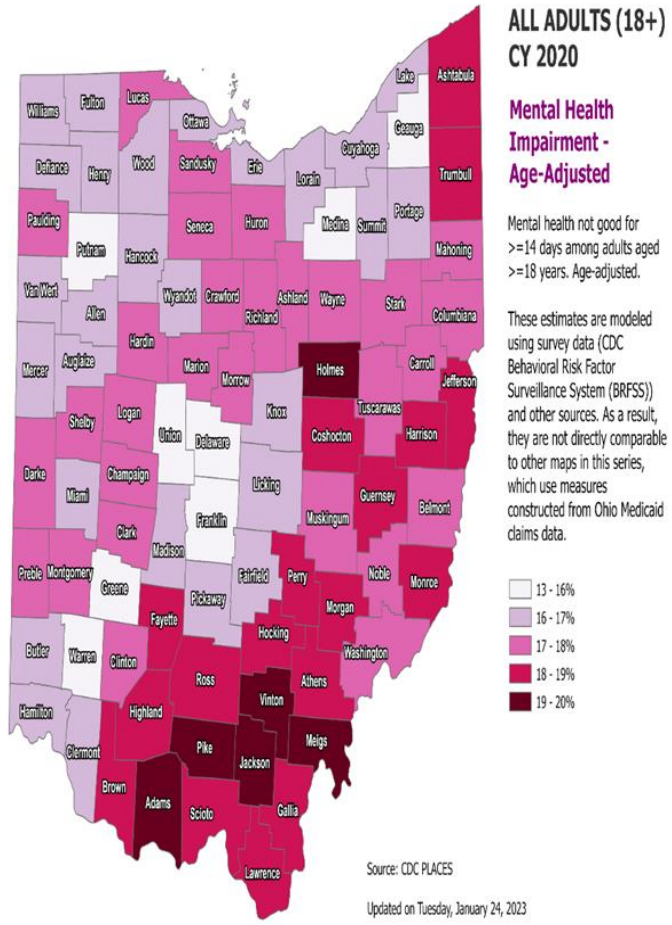
- **Capitation rates are set based on the assumption of successful contracting**
  - » Outlier contracting outcomes are excluded from the base rate
- **Base capitation rates include expectations for quality outcomes and cost containment**
  - » Example: Hospital re-admissions
  - » Example: ER Diversion
- **Utilization or cost are trended forward, but not both**
- **Administrative cost and Healthcare Quality Improvement (HCQI) initiatives are priced and modified to achieve program goals not profit**
  - » Examples With SPBM: decreased MCO admin. Quality/collective impact: increased HCQI.
- **Risk Margin (Profit) = better performance than model plan**
  - » **Contracts are at risk.** We create estimates of what it SHOULD cost to do business in Ohio for their specific members and expected managed care efficiencies. If a plan outperforms this model, they make a profit. If they do not, they lose money.

Acuity Trends and Utilization Examples

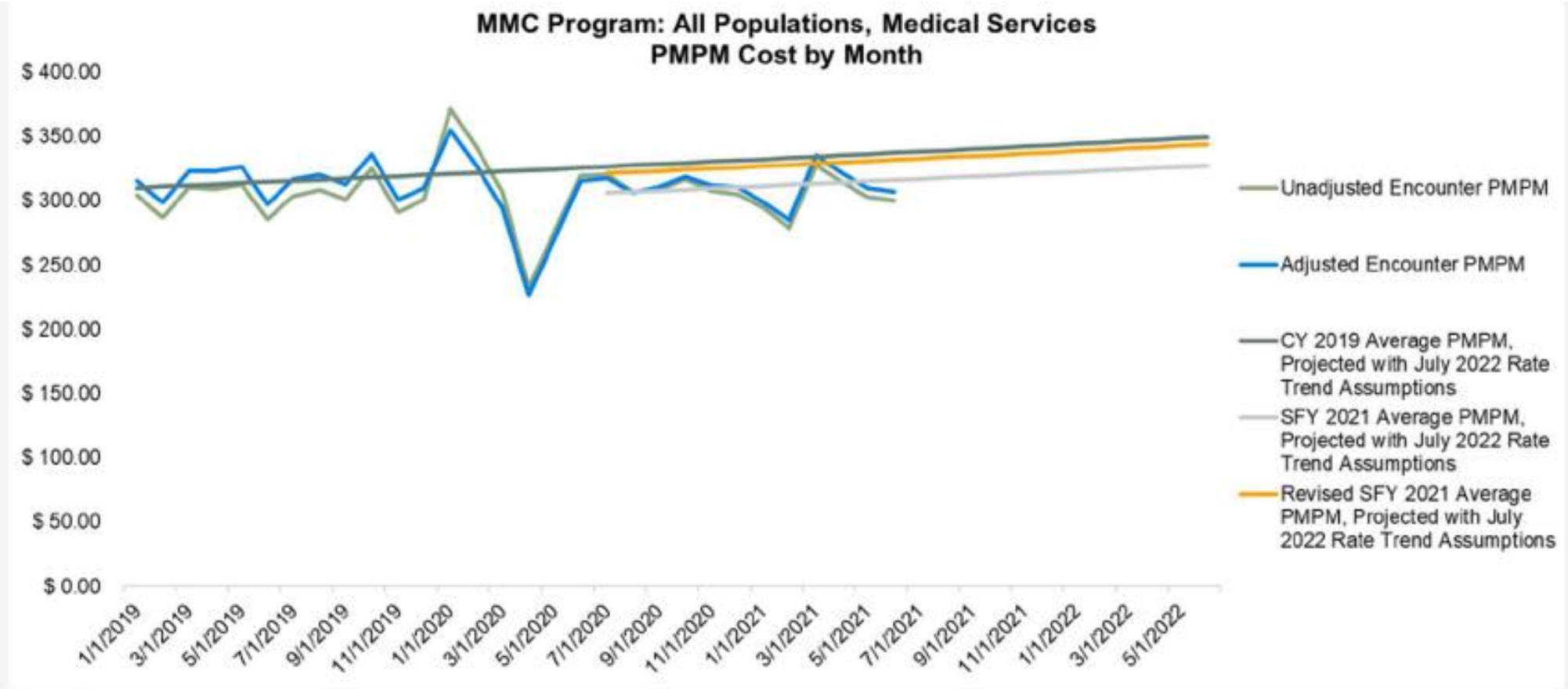
Overall Ohio Adult (18+) CDC Estimated Rates of Diabetes, High Blood Pressure, and Mental Health Impairment







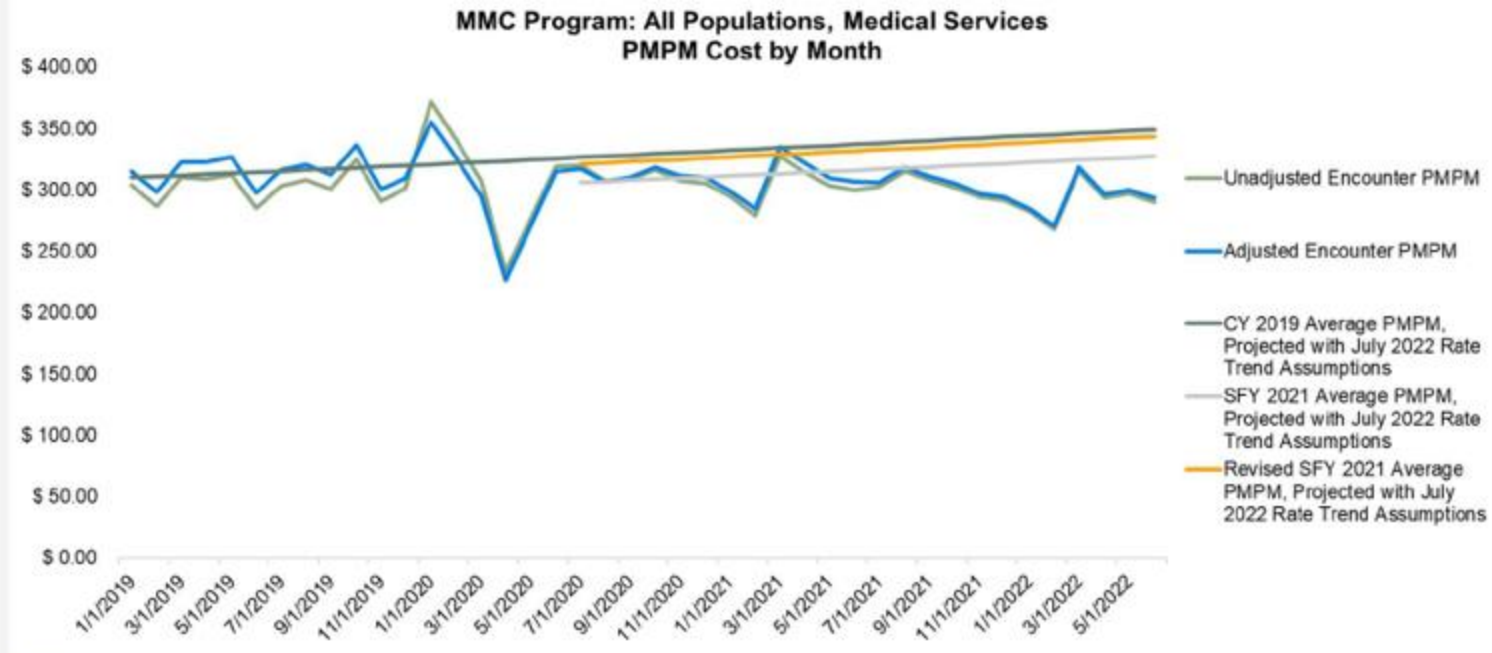
July 2023 MMC Rate Amendment: Post-Covid Data Adj – Initial Trend



Notes:

1. Each incurred month was limited to 3 months of runout.
2. Claims underlying the delivery kick payment are excluded from this chart.
3. For the purpose of the chart, rate cell, region, and service category level PMPM cost was composited using projected July through December 2023 enrollment.

July 2023 MMC Rate Amendment: Post-Covid Data Adj - Emerging Trends



Notes:
1. Each incurred month was limited to 3 months of runout.
2. Claims underlying the delivery kick payment are excluded from this chart.
3. For the purpose of the chart, rate cell, region, and service category level PMPM cost was composited using projected July through December 2023 enrollment.

Covered Populations and Rate Cell Development

The managed care population is composed of low-income children, families, pregnant women, and disabled, and those that meet the income requirement.

- Covered Families and Children (CFC/MAGI): includes children, parents and caretaker populations
- Aged, Blind and Disabled (ABD): limited to non-dual and non-institutional populations
- Expansion (EXP, MAGI Adult): the eligible population under the ACA Medicaid expansion
- Adoption and Foster Kids (AFK): adoption and foster children population.

MyCare is not included in this discussion, but the concepts and process is the same.

ODM operates the Medicaid Managed Care program for the population covered by Medicaid who meet the state-defined criteria for enrollment.

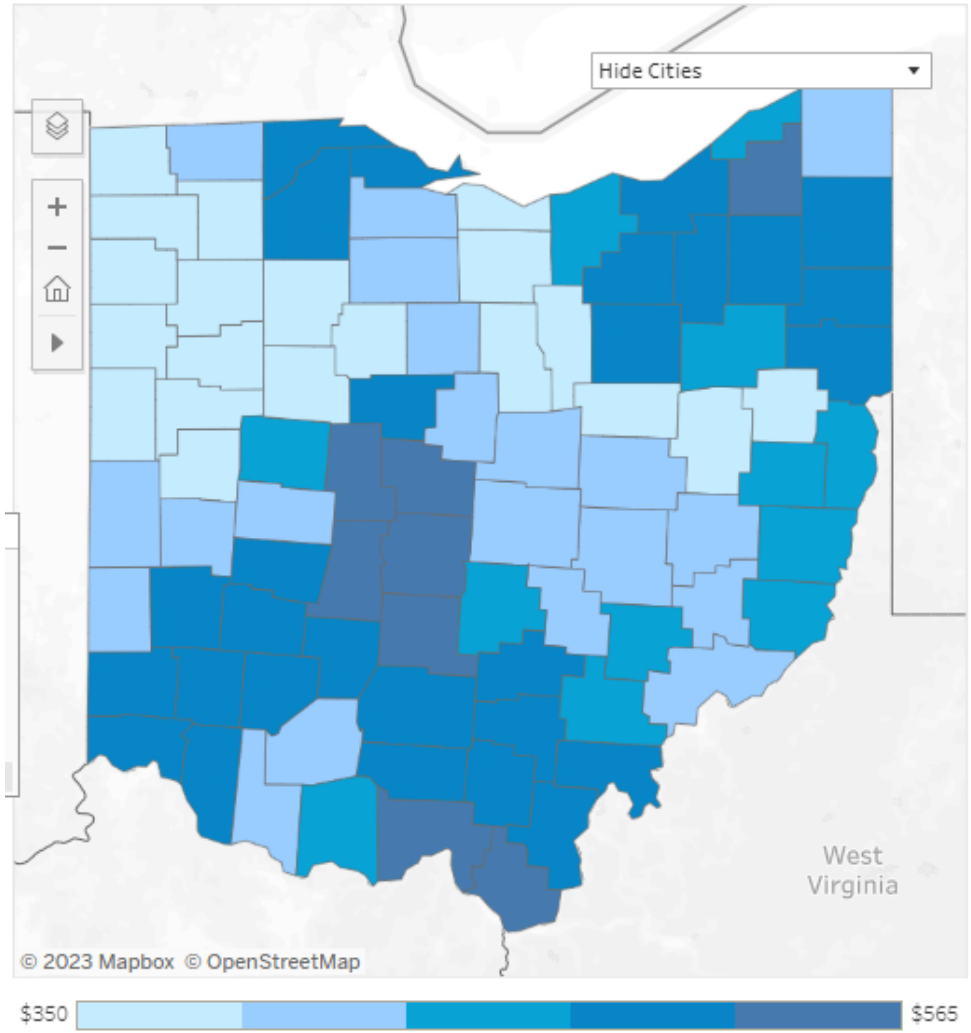
- Within each broad group rates are developed for specific categories
  - Age
  - Gender
  - Region

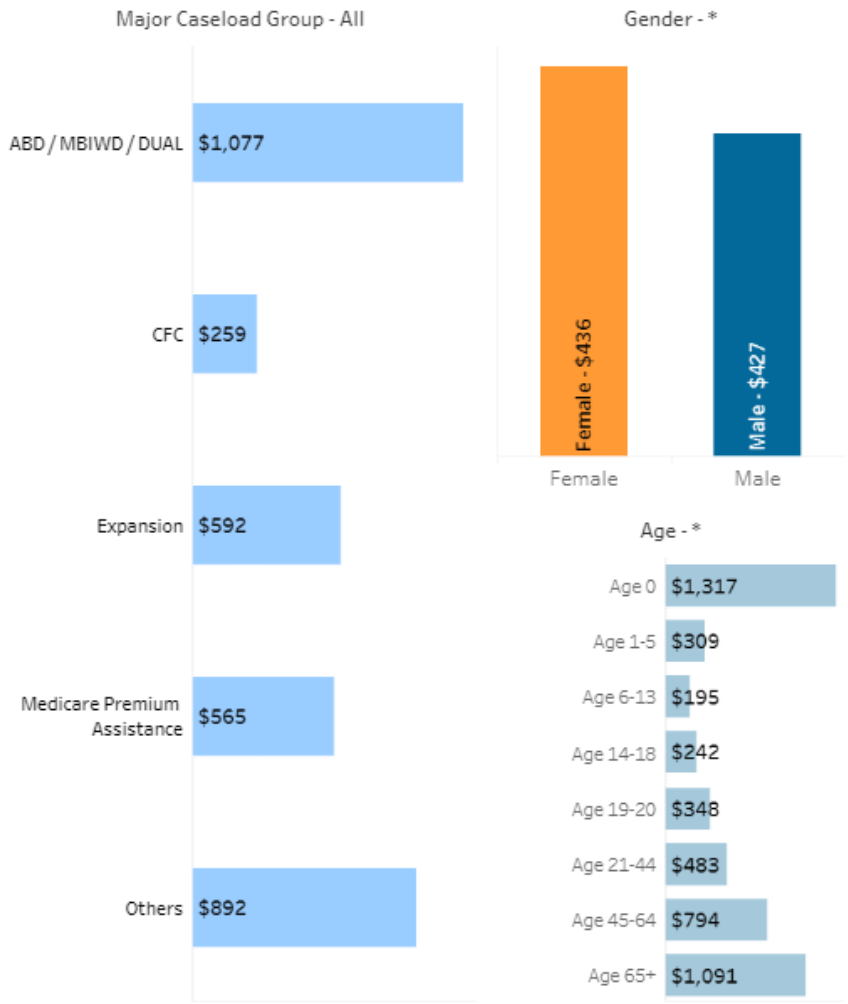
Table 1
Ohio Department of Medicaid
Calendar Year 2021 Capitation Rate Methodology
Managed Care Capitation Rate Cells

Rate Cell	Rate Cell Indicator
CFC HF/HST <1 M+F	RC01
CFC HF/HST 1 M+F	RC02
CFC HF/HST 2-13 M+F	RC03
CFC HF/HST 14-18 M	RC04
CFC HF/HST 14-18 F	RC05
CFC HF 19-44 M	RC06
CFC HF 19-44 F	RC07
CFC HF 45+ M+F	RC08
CFC HST 19-64 F	RC09
CFC Delivery	RC10
EXT 19-34 M	RC11
EXT 19-34 F	RC12
EXT 35-44 M	RC13
EXT 35-44 F	RC14
EXT 45-54 M	RC15
EXT 45-54 F	RC16
EXT 55-64 M	RC17
EXT 55-64 F	RC18
ABD <21	RC19
ABD 21 +	RC20
EXT Delivery	RC21
Adoption and Foster Kids	RC22

Base Rate Geographic and Demographic Distribution

Managed Care Total Expenditure - $1,431,066,284	# of Recipients - 2,917,418	Managed Care Amount PMPM - $490





Actuarially Sound Rates

Must Comply With:

- Actuarial standards of practice applicable to Medicaid managed care rate setting
- Must follow Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) Effective Dec. 2020
- Must follow the Managed Care Rate Development Guide published by CMS adopted in [published annually for rate periods beginning July 1 thru June 30]
- Must be actuarially sound
- Must be certified by CMS

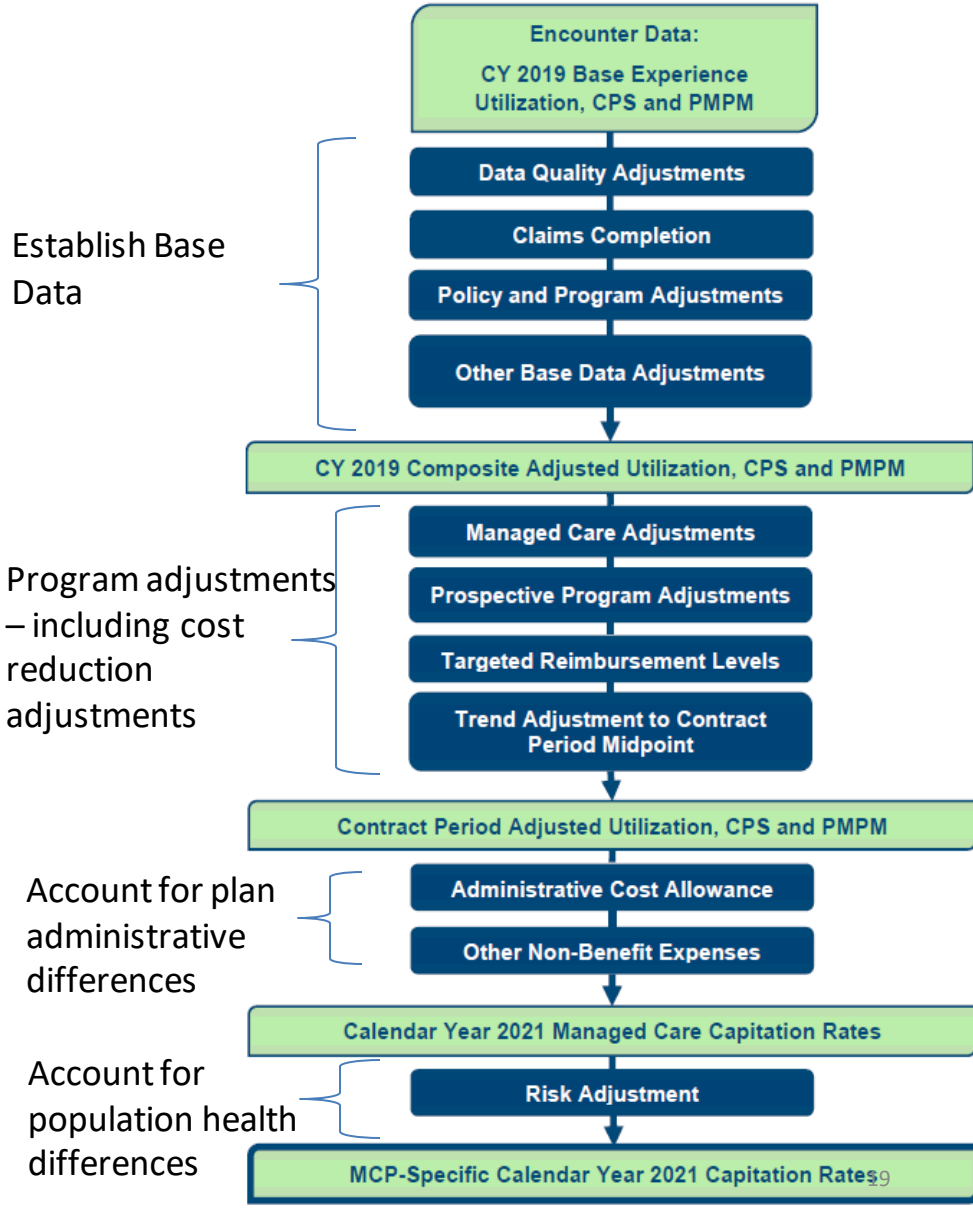
Actuarially Sound Rate Considerations:

- Must cover the appropriate period being certified.
- Rates are set so that they are consistent with revenue sources compared to reasonable, appropriate and attainable costs.
- Revenue examples include; reinsurance, governmental stop-loss cash flows, governmental risk adjustment case flows, investment income, and TPL recovery offset.
- Cost examples include; expected health benefits, settlements, administrative expenses, cost of capital, mandated assessments , fees and taxes.

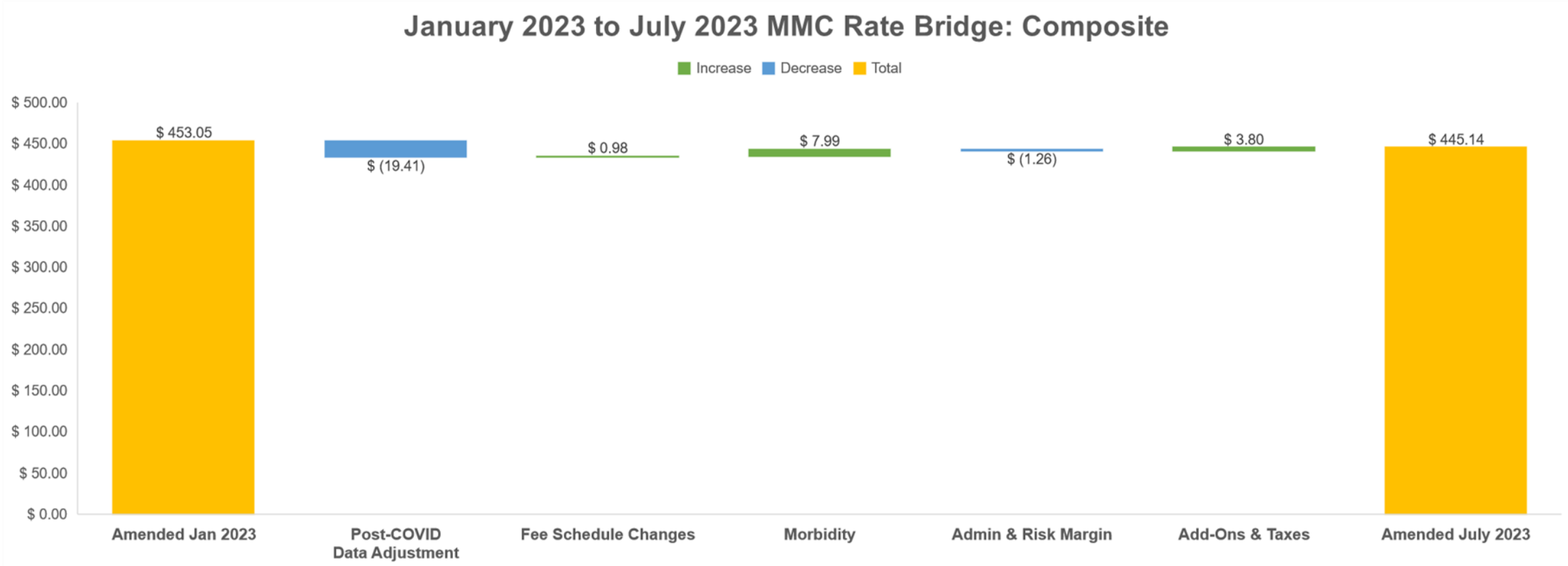
Rate Setting Methodology Process Flow

Steps:

- Step 1: Crate per member per month (PMPM) cost summaries
- Step 2: Apply data quality adjustments
- Step 3: Apply historical and other adjustments to cost summaries
- Step 4: Adjust for prospective program and policy changes and trend to calendar year
- Step 5: Incorporate non-claims items and adjustments
- Step 6: Development and issuance of actuarial certification
- Step 7: Risk adjusted capitation rates



Managed Care* Rates--Changes to 1/1/23 rates to establish 7/1/23 rate amendment



Does not include MyCare

Prior year Example of Summarized Base Data

Table 4 Ohio Department of Medicaid Calendar Year 2021 Capitation Rate Methodology Base Data Reconciliation					
	Base Data				
Rate Cell	Member Months	Cost Report	Adjusted Cost Report	Encounter	Adjusted Encounter
HF/HST <1 M+F	873,437	$ 881.60	$ 899.69	$ 868.77	$ 894.16
HF/HST 1 M+F	770,178	167.37	167.09	163.49	166.22
HF/HST 2-13 M+F	8,413,459	136.01	133.69	133.14	133.08
HF/HST 14-18 M	1,380,594	176.92	171.85	174.11	171.53
HF/HST 14-18 F	1,410,490	214.57	210.47	212.27	210.46
HF 19-44 M	933,437	264.33	260.71	261.65	259.39
HF 19-44 F	3,503,897	373.19	368.79	371.34	369.14
HF 45+ M+F	593,764	548.48	542.69	541.21	537.88
HST 19-64 F	191,711	394.26	386.44	424.68	427.79
Subtotal: CFC	**18,070,967**	**$ 251.55**	**$ 249.31**	**$ 248.62**	**$ 248.98**
EXT 19-34 M	1,376,314	$ 408.80	$ 405.18	$ 413.93	$ 408.94
EXT 19-34 F	1,331,044	397.99	394.30	400.94	396.91
EXT 35-44 M	721,304	595.98	591.70	602.33	597.38
EXT 35-44 F	652,315	615.66	611.20	617.11	612.41
EXT 45-54 M	672,502	758.67	754.24	757.44	752.91
EXT 45-54 F	742,732	769.20	764.94	767.99	763.52
EXT 55-64 M	584,528	887.86	883.87	881.74	879.51
EXT 55-64 F	685,310	811.46	807.52	804.52	802.04
Subtotal: EXT	**6,766,049**	**$ 603.08**	**$ 599.08**	**$ 604.03**	**$ 599.86**
ABD <21	629,186	$ 889.30	$ 857.77	$ 853.82	$ 842.68
ABD 21 +	1,800,678	1,276.24	1,270.56	1,268.24	1,255.11
Subtotal: ABD	**2,429,864**	**$ 1,176.05**	**$ 1,163.67**	**$ 1,160.93**	**$ 1,148.32**
AFK Population	404,877	$ 523.44	$ 515.61	$ 516.42	$ 515.84
CFC & EXT Delivery	51,687	$ 4,582.09	$ 4,582.09	$ 4,512.00	$ 4,771.19
Total	**27,671,757**	**$ 431.22**	**$ 427.58**	**$ 427.98**	**$ 426.56**

Other Key Concepts

Concepts and Dynamics of Total Program Cost:

- Base Year & Trend
- Morbidity
  - Overall "illness" or complexity of the pool of individuals
- Morbidity & Changes in Utilization & Overall Cost
  - Morbidity can go up, but costs still go down -- if utilization remains low and caseload drops
  - Caseload can go down but costs not decrease -- depending on morbidity
- Risk Adjustment
  - Each plan is adjusted for the health of their specific population
- Medical Loss Ratio
- Rate setting period: typically calendar year, but during the PHE we used two 18 month periods.
- Payment add-ons or other considerations: newborn kick payment; risk pools or risk corridors, if applicable; performance incentives or withholds.

Quality & Cost Management Strategies

5162.70 Joint Medicaid Oversight Committee Cost Containment Provisions

In 2014, the Ohio General Assembly enacted ORC 5162.70, requiring the Ohio Department of Medicaid (ODM) to **limit the per-person growth of the Medicaid program by enacting reforms that accomplish various goals identified in the statute**.(ORC 5162.70 (B)(2)(a-g))

(B) The Medicaid director shall implement reforms to the Medicaid program that do all of the following:

(2) Achieve the limit in the growth of the per recipient per month cost of the Medicaid program under division (B)(1) of this section by doing all of the following:

a) Improving the physical & mental health of Medicaid recipients.
b) Providing for Medicaid recipients to receive services in the most cost-effective & sustainable manner.
c) Removing barriers that impede Medicaid recipients' ability to transfer to lower cost, and more appropriate services, including home & community-based services (HCBS).
d) Establishing Medicaid payment rates that encourage value over volume & result in Medicaid services being provided in the most efficient & effective manner possible.
e) Implementing fraud/ abuse prevention & cost avoidance mechanisms to the fullest extent possible.
f) Reducing the prevalence of comorbid health conditions and mortality rates of Medicaid recipients.
g) Reducing infant mortality rates among Medicaid recipients.

Report Provided to JMOC and Included with Budget Testimony (Updated April 13, 2023)

ODM Initiatives	Examples and Details	Criteria Met from ORC 5162.70 (B)(2)(a)-(g) *and* Next Generation (1) to (19)
which aims to improve mental health and substance use prevention, treatment, and recovery support services. Medicaid's SFY 24-25 budget proposals aim to further improve access to appropriate services so people with behavioral health needs can get and stay well.	• Medicaid is currently enhancing coverage of Applied Behavioral Analysis (ABA) for children and youth with Autism Spectrum Disorder (ASD). This early intervention service helps kids with ASD reach their maximum potential. Benefit enhancements will help to clarify coverage for a seamless approach across the Medicaid delivery system.	• (2) wellness and preventative care • (6) health and cultural respect • (10) OhioRISE • (11) Additional services for youth
Expanding access to care via telehealth	• ODM responded immediately to the pandemic by introducing telehealth flexibilities. • ODM is maintaining access to remote care to help patients conveniently and quickly access the high quality physical and behavioral health care they need. It also expands access to services or types of specialty providers who would otherwise be more difficult to schedule appointments with or require a longer distance commute. Appropriate use is monitored to ensure that face to face meetings occur.	• (b) Cost effective, sustainable services • (d) Rates = value • (2) wellness and preventative care • (7) telehealth • (8) 24/7 nurse line • (9) after hours BH crisis • (19) easing provider burden

Sample from 9 page report

Additional Quality and Cost Management Features

MCO-specific

- Quality Withhold
- MCO efficiency

Value Based Payment Programs & Early Intervention Services

- Care innovation and community improvement programs (CICIP)
- Comprehensive Primary Care (CPC); also CPC-kids and Comprehensive Maternal Care and other enhanced maternal/infant care programs

Other System Designs

- SPBM & Pharmacy Pricing & Audit Consultant (PPAC)
- Unified Preferred Drug List (UPDL)
- Tiered Dispensing fee

MMC Quality Withhold Program Summary

- The MMC Quality Withhold Program is an all-plan collaborative effort following proven QI methods to accelerate improvement of health outcomes of priority populations enrolled in Managed Care
- Three Projects:
  - » Pregnancy Risk Assessment Form (PRAF) Submissions to
    - Identify pregnancy risks and activate enhanced supports, e.g., CareGuides, transportation
    - Communicate with Ohio's Benefit system to update pregnancy status and ensure eligibility through pregnancy and during the first year of the infant's life;
    - Serves as a referral to WIC and Home Visiting
  - » Continuous Glucose Monitors (CGM) to provide a tool to manage diabetes and avoid serious medical complications
  - » Diabetes Self-Management Education (DSME) to provide an evidence-based foundation to empower people to manage diabetes
- Goals
  - » Complete 5 milestones of the proven QI process
  - » Improve utilization/submission rates over baseline to the established SMART Aim for each project
- Timeline: July 2022 – December 2023

MMC Quality Withhold Program Summary

	PRAF	CGM	DSME
People Impacted	~70,000 Pregnant Women	121,186 Members aged 18 to 75 with diabetes	121,186 Members aged 18 to 75 with diabetes
Dollars Tied to Success (3% of Capitation Payments are Withheld)	~$400 million	~$140 million	~$140 million
SMART AIM & Progress over Baseline	Increased from 330 to 700 average weekly PRAF submissions (Goal is 850/wk)	Increased CGM use over baseline indicates significant progress towards the goal	Increased DSME use over baseline indicates progress significant towards the goal
Status of QI Process (Must Complete 5 Milestones)	Working on Milestone 3: Designing and progressively testing changes to inform Implementation, sustainability, and spread of adopted interventions	Working on Milestone 3 Designing and progressively testing changes to inform Implementation, sustainability, and spread of adopted interventions	Working on Milestone 3 Designing and progressively testing changes to inform Implementation, sustainability, and spread of adopted interventions
Examples of Interventions or Learnings	Partnering with CBOs; Integration of PRAF into EHRs	Removal of prior authorization through DME; Reduce provider administration; Partnering with CBOs;	Coverage of DSME; Collaborative effort with DSME providers & ODH; Telehealth

Discussion and Questions

PHE Addendum

Transition to normal operations

- ODM began discussions with CMS in the fall of 2020. Obviously, the transition was a moving target depending on when the end of the PHE.
- Ongoing dialogue was maintained with the other human services cabinet agencies, both for specific program responsibilities (ODMHAS, DODD, ODA), as well as for the impact on individuals served, county JFS and other local stakeholders (JFS, ODH, County Boards, ODE/schools, etc.)
- Particular emphasis was paid to communication with 'grass roots' organizations; foodbanks, legal aide organizations, other CBOs, and CDJFSs who would have involvement with individuals served.
- ODM maintained services and relief payment structures for the duration of the PHE.
- ODM conducted 9 webinars prior to any amendments to waivers to get input on all the waivers/flexibilities and potential changes.
- Public Notices were published in July and August 2023 soliciting input on waiver changes.
- Rules went through clearance and further input is accepted. Last of the rules will be proposed for filing in the next couple of weeks.
- In summary, ODM has endeavored to provide a completely open flow of information and dialogue/feedback from individuals, families and other stakeholders across the board. Regular discussions and webinars were held throughout the pandemic, even if only to update folks during times of particular uncertainty.

#	Category	Description	Impacted Waivers	Post-PHE Status
PHE 3	Exceed Service Limitations	Allow Shared Living services to be billed on the same day as HPC and/or PD-HPC, but not by the same direct support professional (DSP). In this instance, billing will not be permitted at the same time for Shared Living and HPC and/or PD-HPC.	**IO**	**DISCONTINUE**
PHE 4	Exceed Service Limitations	Combining the current budget limitations for residential and non-residential services to allow individual access to more funds for their waiver service needs. Individuals will have access to a total amount of $58,232. Individuals will still have access to emergency funds which will total $8,520 within a three-year period.	**L1**	**DISCONTINUE**
PHE 5	Exceed Service Limitations	On an individual basis, and when identified by the individual's care team, DODD may prior authorize additional time needed for residential and community respite. This prior authorization will only occur if a health and welfare risk is identified by the care team, and the team supports the continued stay of an individual in a facility within the guidelines prescribed by the Ohio Department of Health	**IO**	**DISCONTINUE**
PHE 6	Exceed Service Limitations	Community Respite may be authorized for an additional 60 days for a total of 120 days during an individual's twelve-month waiver span. The increased limitation will not exceed what has been approved in the Appendix K document (i.e., no more than 180 days for Residential Respite or 120 days for Community Respite) and the increased limitation will not cross a new twelve-month waiver span (i.e., unused Respite limits will not carry over into a new waiver span).	**IO, L1, SELF**	**DISCONTINUE**
PHE 8	Exceed Service Limitations	Residential Respite may be authorized for an additional 90 days for a total of 180 days during an individual's twelve-month waiver span.	**L1, SELF**	**DISCONTINUE**
PHE 9	Exceed Service Limitations	The State permits delivery of bulk meals as not to exceed a total of what would constitute 2 meals per day.	**OHC, PP, MC**	**DISCONTINUE**
PHE 11	Expansion of Provider Certification to Other Services	Adult Day Habilitation providers may become certified to provide HPC and/or Participant-Directed HPC services in the residential setting to individuals who are unable to attend a day program due to either their health or a mandatory closure of the program AND Adult Day Habilitation providers may become quickly certified to provide all respite services to individuals in emergency need of this service AND Vocational Habilitation providers may become certified to provide HPC and/or Participant-Directed HPC services in the residential setting to individuals who are unable to attend a day program due to either their health or a mandatory closure of the program AND Vocational Habilitation providers may become quickly certified to provide all respite services to individuals in emergency need of this service.	**IO, L1**	**DISCONTINUE**

#	Category	Description	Impacted Waivers	Post-PHE Status
PHE 23	Provider Qualifications	Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers. [Allow adult day providers to be credentialed to provide home delivered meals]	**OHC, PP, MC**	**DISCONTINUE**
PHE 25	Provider Training	Agencies can assume initial training requirements have been met as part of the independent provider certification process but must provide the independent provider with major unusual incidents (MUIs) and unusual incidents (UI) training specific to the Agency. Agencies must provider person-specific training and emergency response training for the locations in which the independent provider will be working. The condensed training referenced in the Resources for Onboarding DSPs guidance is acceptable.	**IO, L1, SELF**	**DISCONTINUE**
PHE 26	Provider Training	Online Cardiopulmonary Resuscitation (CPR)/First Aid classes will be accepted	**IO, L1, SELF**	**DISCONTINUE**
PHE 27	Remote Case Management	☒ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for: i. ☒ Case management AND Face to face monitoring as outlined in a person's individualized service plan will temporarily be extended and will resume after at least 60 days. Health and welfare must be ensured during this time. AND ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings. AND The annual redetermination process may temporarily take place without a face to face meeting, but rather by telephone or other electronic means, in accordance with HIPAA. A focus on health and welfare will always be present and ensured. AND No more than 60 days after the Appendix K expires, Service and Support Administrators will be asked to verify assessments conducted during the emergency period using a face-to-face method. AND Initial and redetermination level of care assessments may be completed by the Service and Support Administrator temporarily using telephone or email to complete the required assessment, in accordance with Health Insurance Portability and Accountability Act (HIPAA). o No more than 120 days after the Appendix K expires, Service and Support Administrators will be asked to verify assessments conducted during the emergency period using a face-to-face method.	**IO, L1, SELF**	**DISCONTINUE**

#	Category	Description	Impacted Waivers	Post-PHE Status
PHE 12	Expansion of Provider Certification to Other Services	Non-Medical Transportation (NMT) providers may become certified to provide Participant-Directed HPC services in the residential setting to individuals who are unable to attend a day program due to either their health or a mandatory closure of the program.	**SELF**	**DISCONTINUE**
PHE 13	Expansion of Provider Certification to Other Services	NMT providers may become certified to provide HPC and/or Participant-Directed HPC services in the residential setting to individuals who are unable to attend a day program due to either their health or a mandatory closure of the program.	**IO, L1**	**DISCONTINUE**
PHE 16	HCBS Settings Modification	Not comply with the HCBS settings requirement of 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.	**AL, OHC, PP, MC**	**DISCONTINUE**
PHE 17	HCBS Settings Modification	Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic. AND on March 22, 2020, by order of the Director of the Ohio Department of Health, "all individuals currently living within the State of Ohio are ordered to stay at home or at their place of residence..." with exceptions specified in the order. For this reason, the State has checked the below box relative to non-compliance with HCBS regulations regarding visitation at the time of an individual's choosing.	**IO, L1**	**DISCONTINUE**
PHE 18	Program Eligibility	The State permits individuals enrolled on the Ohio Home Care Waiver program who reach their 60th birthday to remain enrolled on the waiver for the duration of the emergency. Individuals are to be disenrolled from the Ohio Home Care Waiver at their next face-to-face assessment following the expiration of the emergency.	**OHC**	**DISCONTINUE**
PHE 19	Provider BCI	Agency providers hiring currently certified independent providers for direct services may forgo obtaining a BCI check if the independent provider is currently certified by DODD.	**IO, L1, SELF**	**DISCONTINUE**
PHE 20	Provider Deeming: DODD Waiver Program/Service Specific	Allowing waiver providers with an active Medicaid provider agreement to furnish waiver services across delivery systems without being subject to additional provider standards and certification processes specific to waiver programs.	**IO, L1, SELF**	**DISCONTINUE**
PHE 21	Provider Deeming: NF Waiver Program/Service Specific	Allowing waiver providers with an active Medicaid provider agreement to furnish waiver services across delivery systems without being subject to additional provider standards and certification processes specific to waiver programs.	**OHC, PP, MC**	**DISCONTINUE**
PHE 22	Provider Deeming: ODM Granting Authority	Allow waiver providers with an active Medicaid provider agreement to furnish waiver services across the delivery systems without being subject to additional provider standards and certification processes specific to the waiver programs.	**PP, IO, L1, SELF**	**DISCONTINUE**

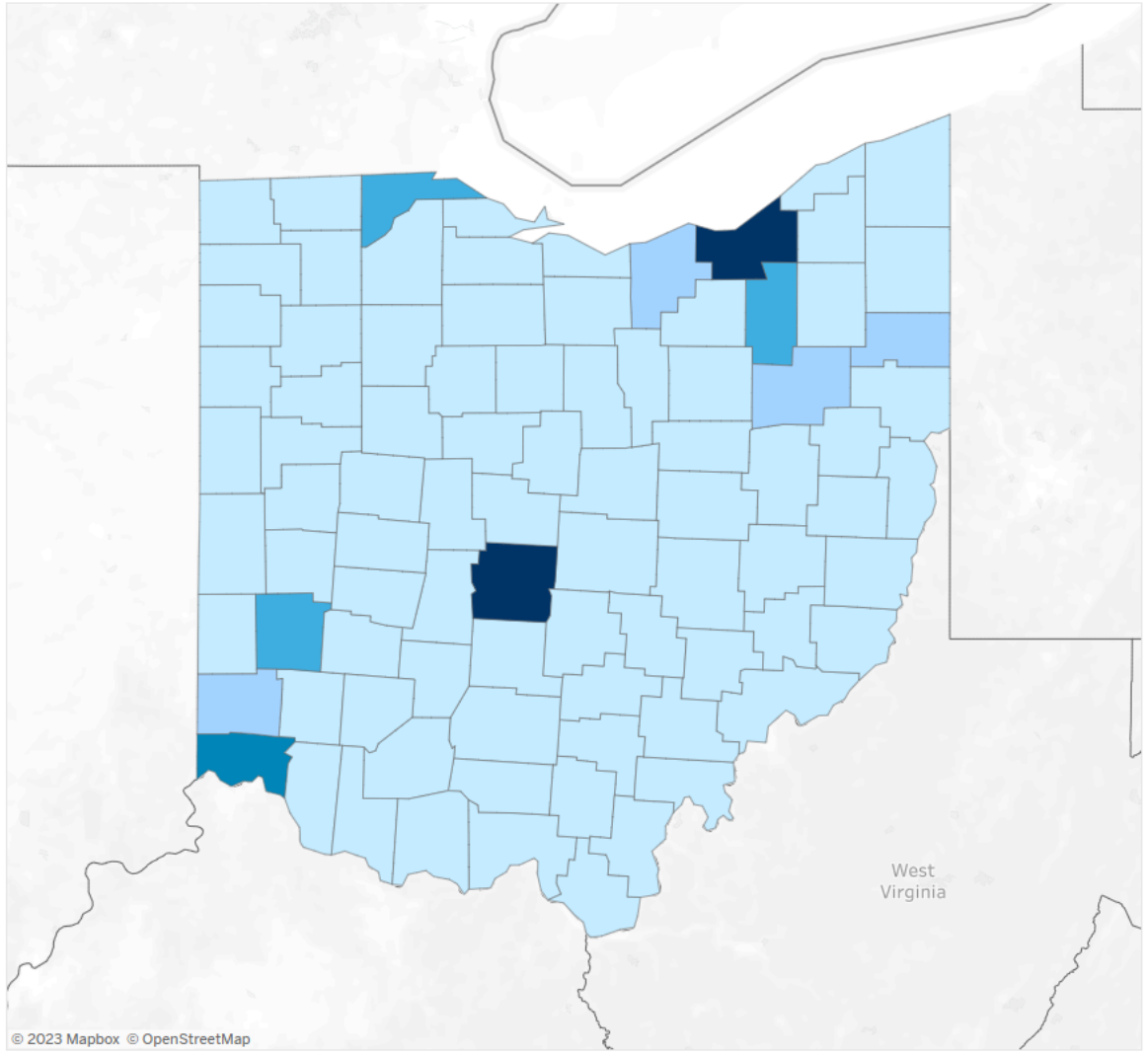
#	Category	Description	Impacted Waivers	Post-PHE Status
PHE 28	Remote Case Management	Ohio modifies in-person or face-to-face requirements for any state plan service or assessment, as described in Attachment 3.1-A of the state plan, as necessary to prevent virus transmission, and authorizes use of telephonic or other substitutes for in-person or face-to-face requirements.	**AL, OHC, PP, MC**	**DISCONTINUE**
PHE 31	Service Authorization	Adjust prior approval/authorization elements approved in waiver.	**AL, OHC, PP, MC**	**DISCONTINUE**
PHE 36	Service Provision Setting Expansion	The State permits expanding settings where services, including but not limited to, adult day can be furnished.	**OHC, PP, MC**	**DISCONTINUE for NF-based**
PHE 37	Service Provision Setting Expansion	The State permits the use of the living units in ODA-certified assisted living facilities which are not single occupancy living units with full bathrooms during the timeframe identified in the approved Appendix K.	**AL, MC**	**DISCONTINUE**
PHE 38	Structural Compliance Reviews	The State may suspend structural compliance reviews.	**AL, OHC, PP**	**DISCONTINUE**
PHE 39	Structural Compliance Reviews	Will suspend the DODD Office of System Support and Standards (OSSAS) regularly scheduled compliance reviews and regulatory work (including Plans of Correction and Plans of Correction-Verification). Reviews are temporarily postponed until at least May 31st, or until the direction of the Director of DODD. OSSAS will continue to conduct special compliance reviews if necessary and will issue citations regarding health and safety or infection control, which will require provider to immediately correct issues.	**IO, L1, SELF**	**DISCONTINUE**
PHE 40	Provider Payments	Quarterly provider payments.	**IO, L1, SELF**	**DISCONTINUE**

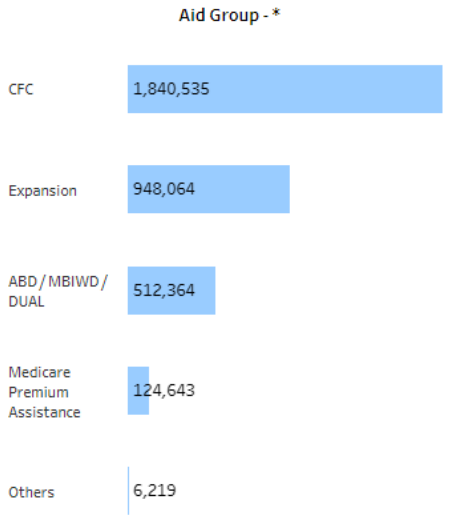
Capitation Addendum

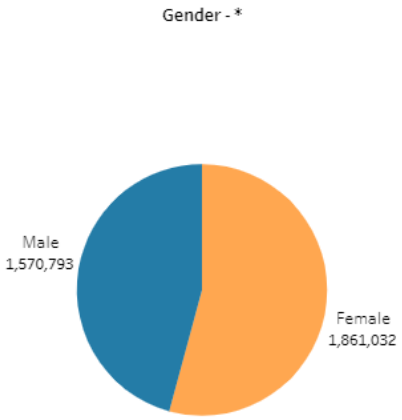
Current Medicaid Population

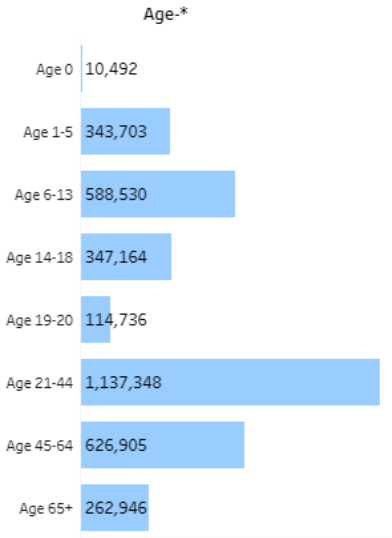
Managed Care - 3,050,263	Fee For Service - 250,700	Limited - 130,862	Total Enrollments - 3,431,825

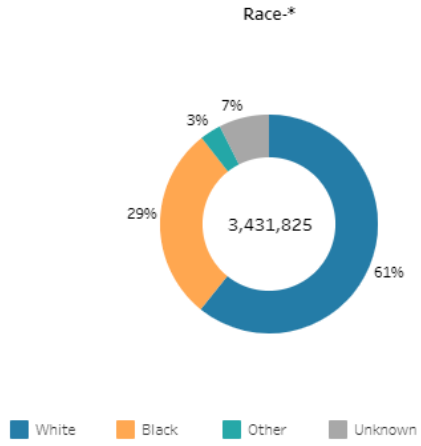
* is for State wide info.







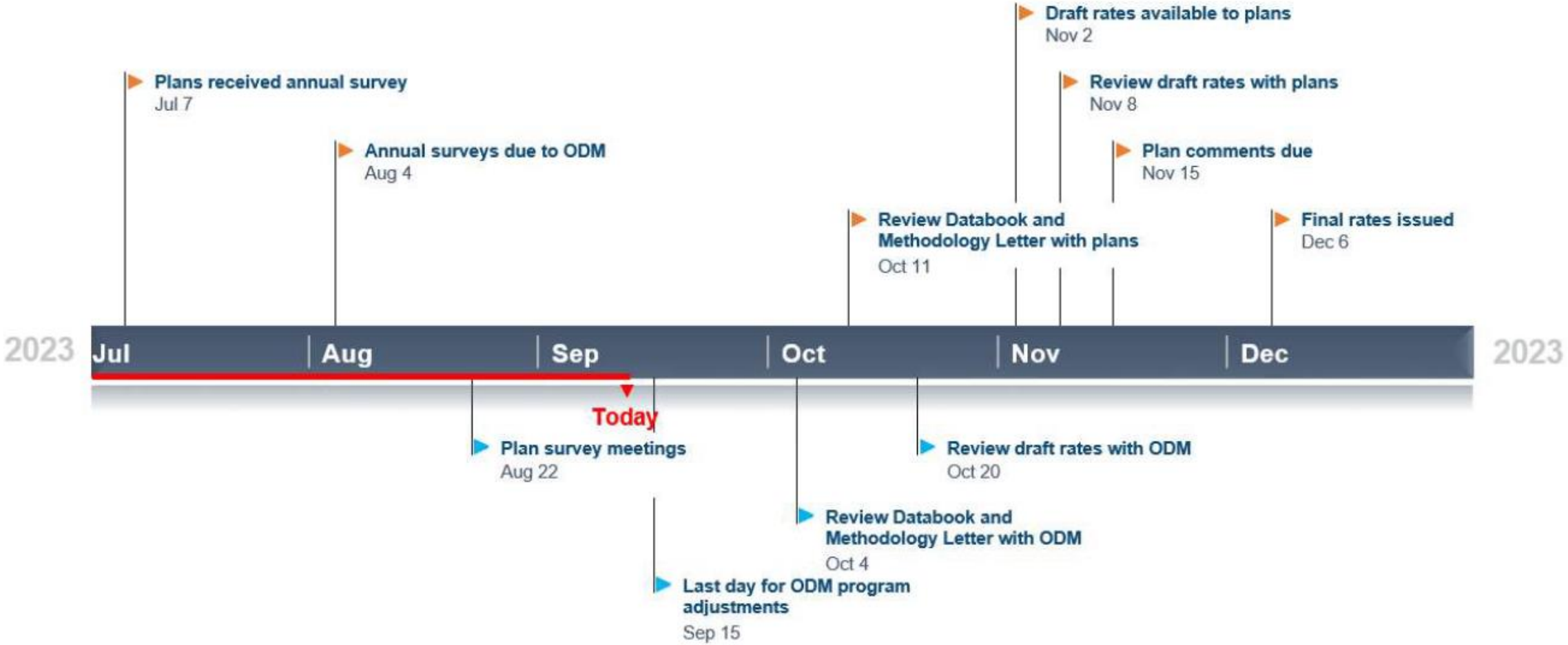




Rate Setting Estimated Timeline

Specific dates are tentative and subject to change

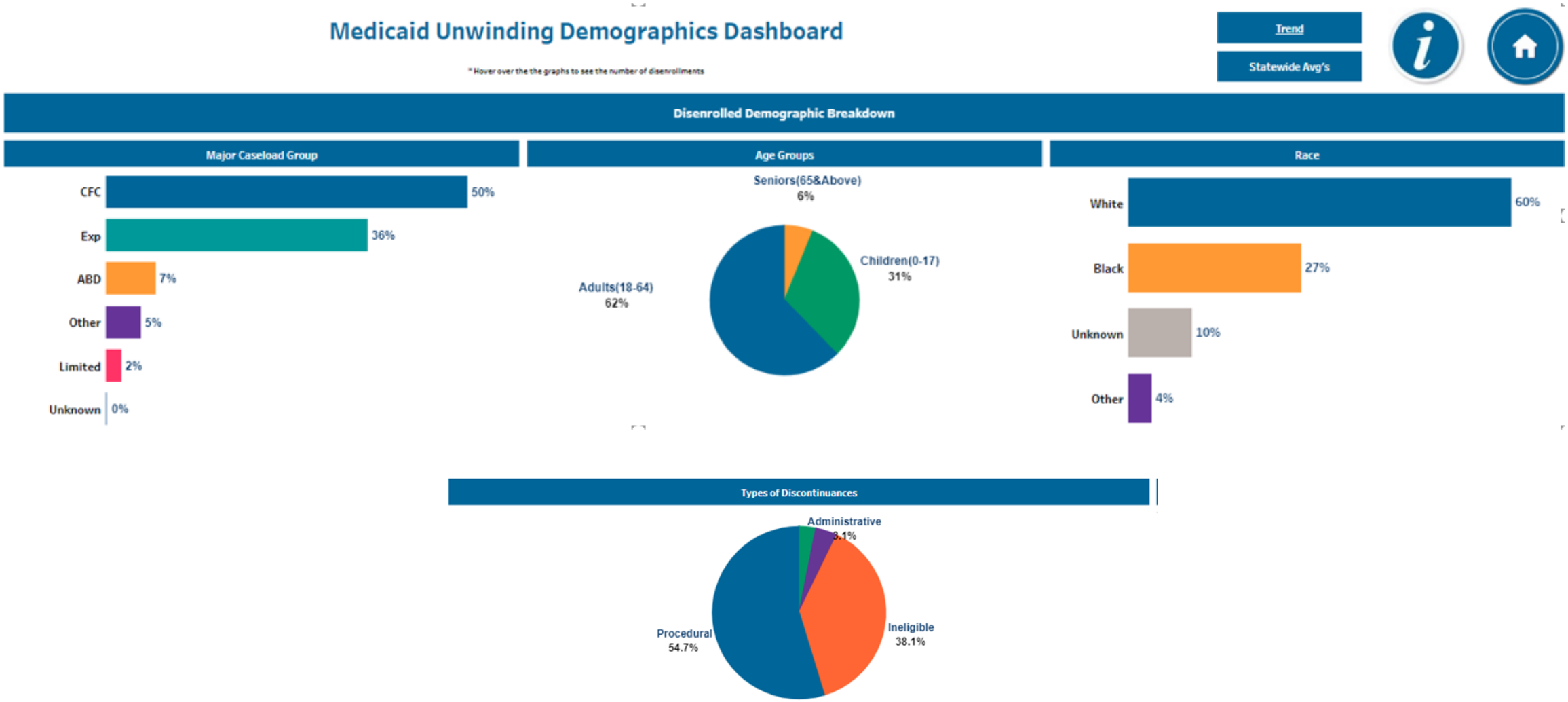
DRAFT CY 2024 RATE TIMELINE FOR ODM REVIEW



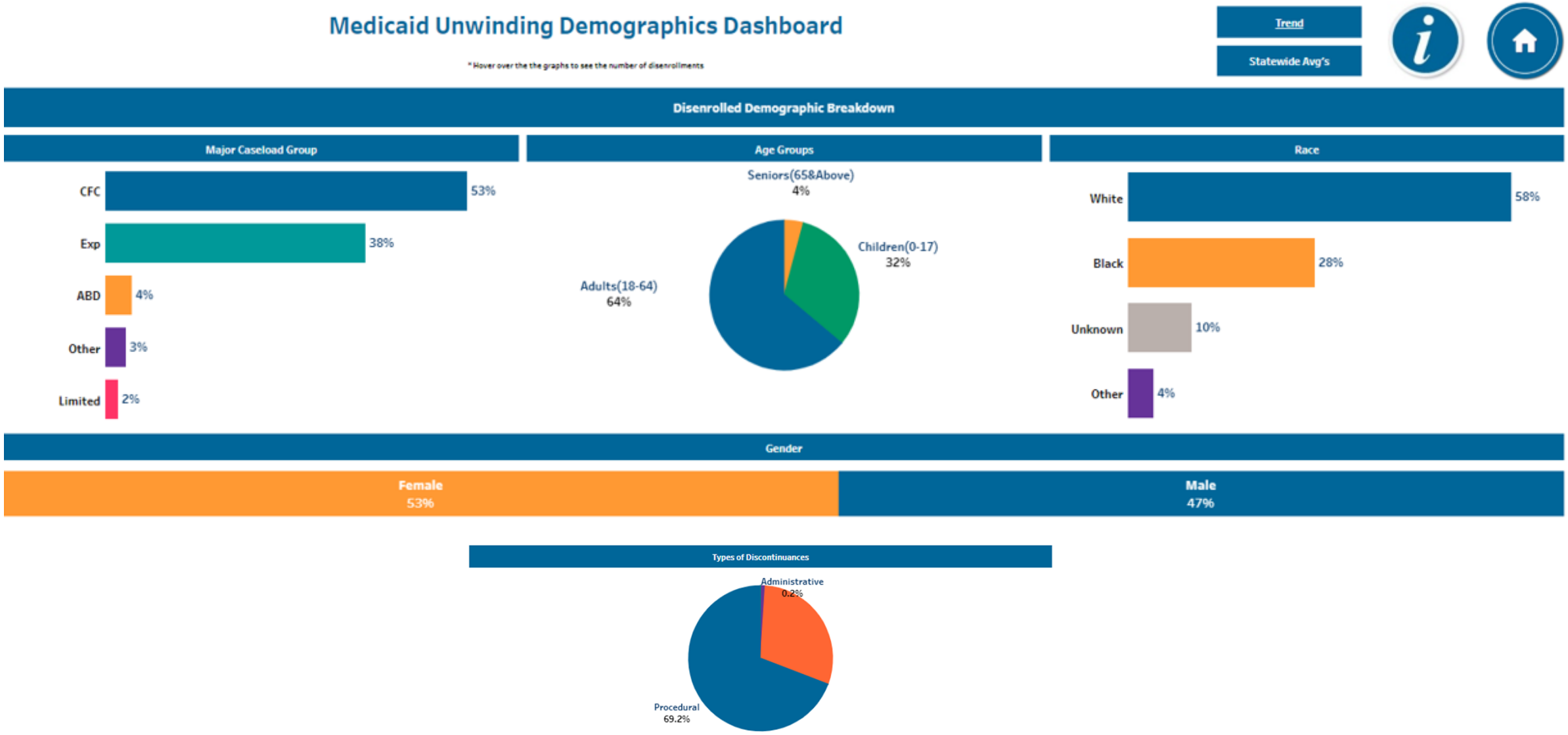
Rate Setting Timeline Activities

- Gather cost reports
- Submit surveys to plans
- Meet with each plan get feedback on assumptions
- Program adjustments
- Review methodology letter with plans
- Draft rates available for plans
- Comments
- Adjustments
- CMS certification
- Final submission

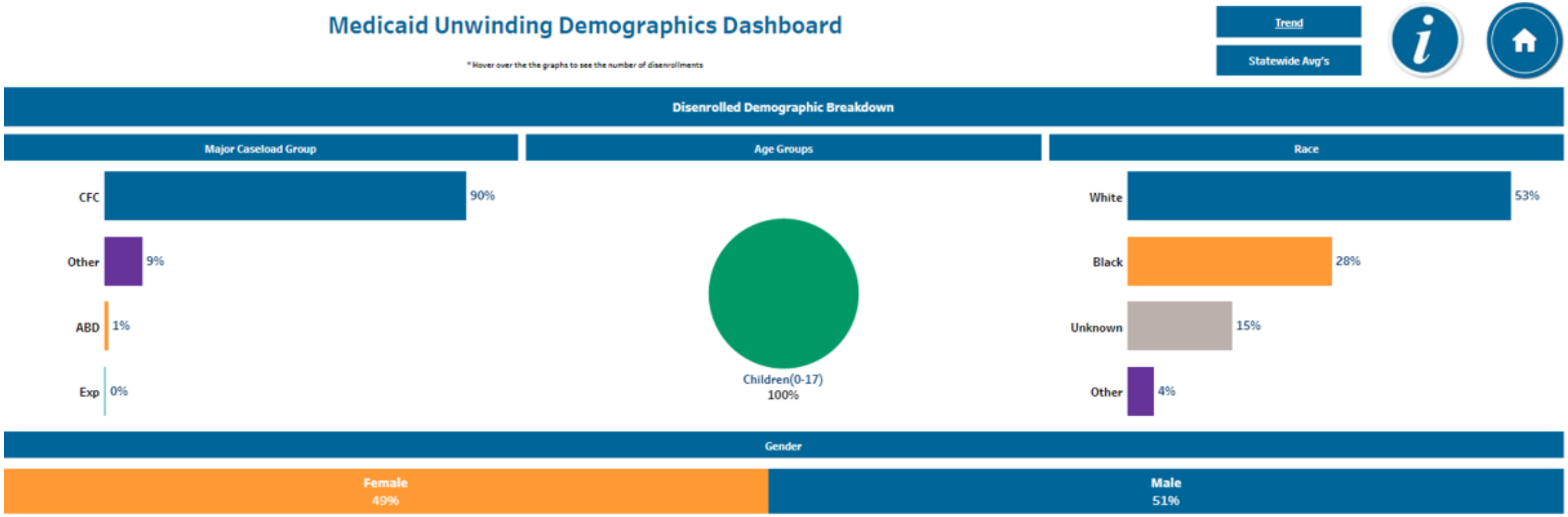
Total Disenrollment Trends



Disenrollment as a Result of Redeterminations

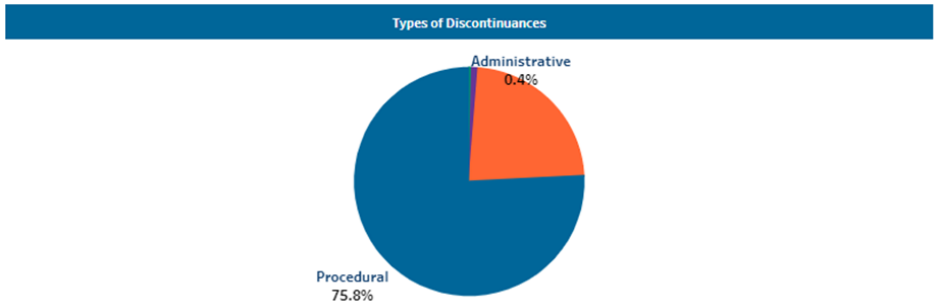


Children's Disenrollment as Part of Redetermination

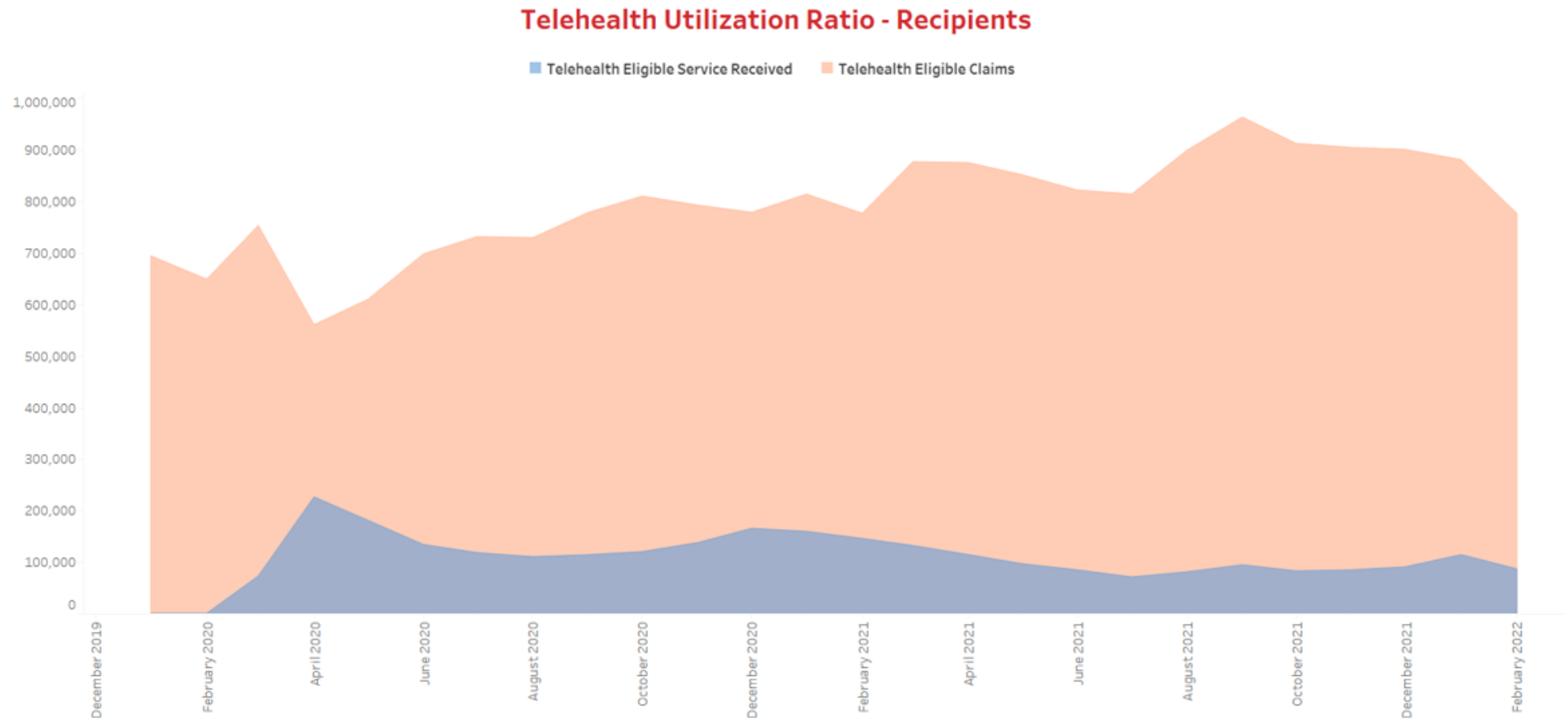


4,125 of these children have already reenrolled

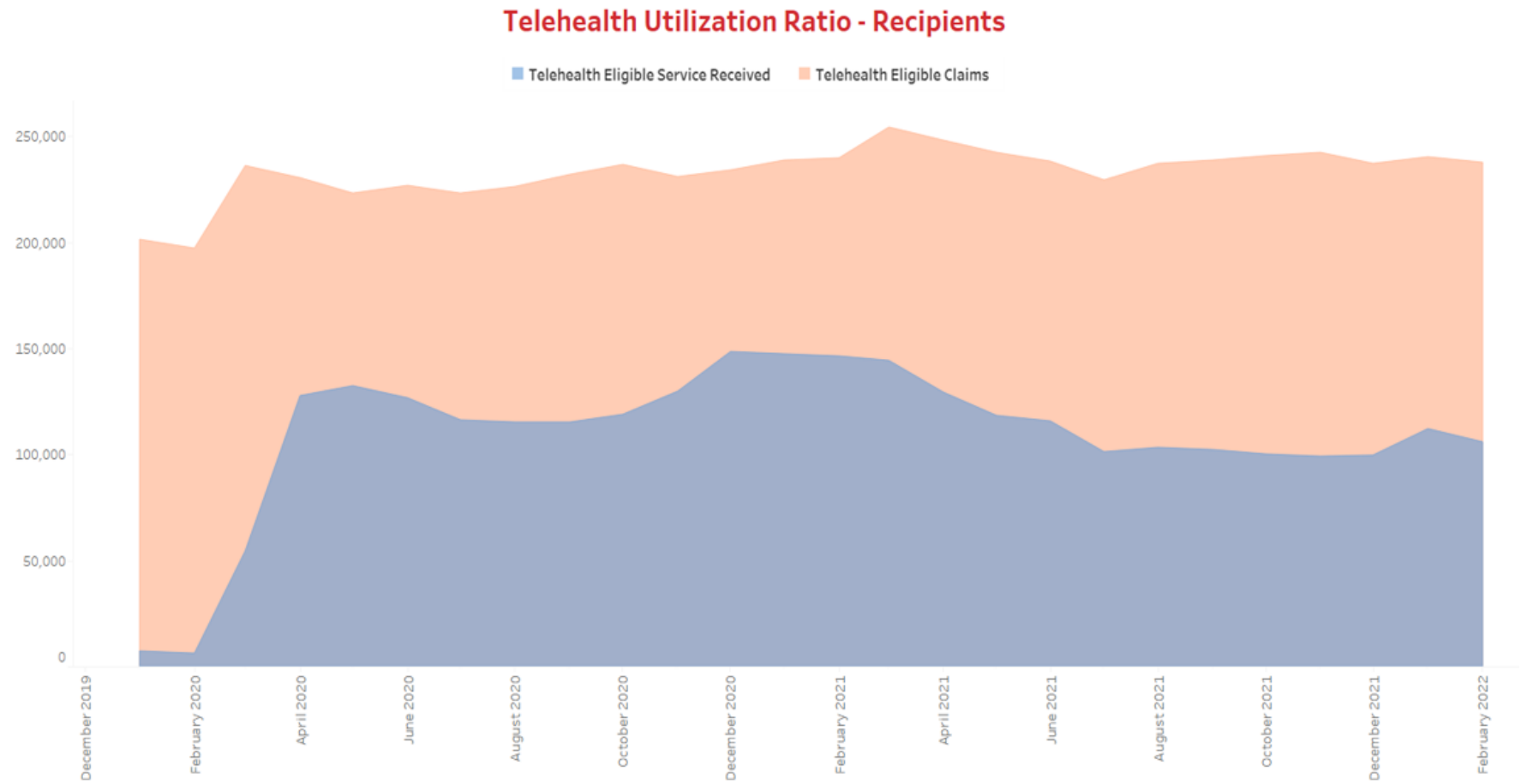
An additional 6,177 have been identified for reenrollment based on eligibility data available to ODM



Medicaid Patient's Utilization of Telehealth Services
All Providers and Claims Eligible for Telehealth

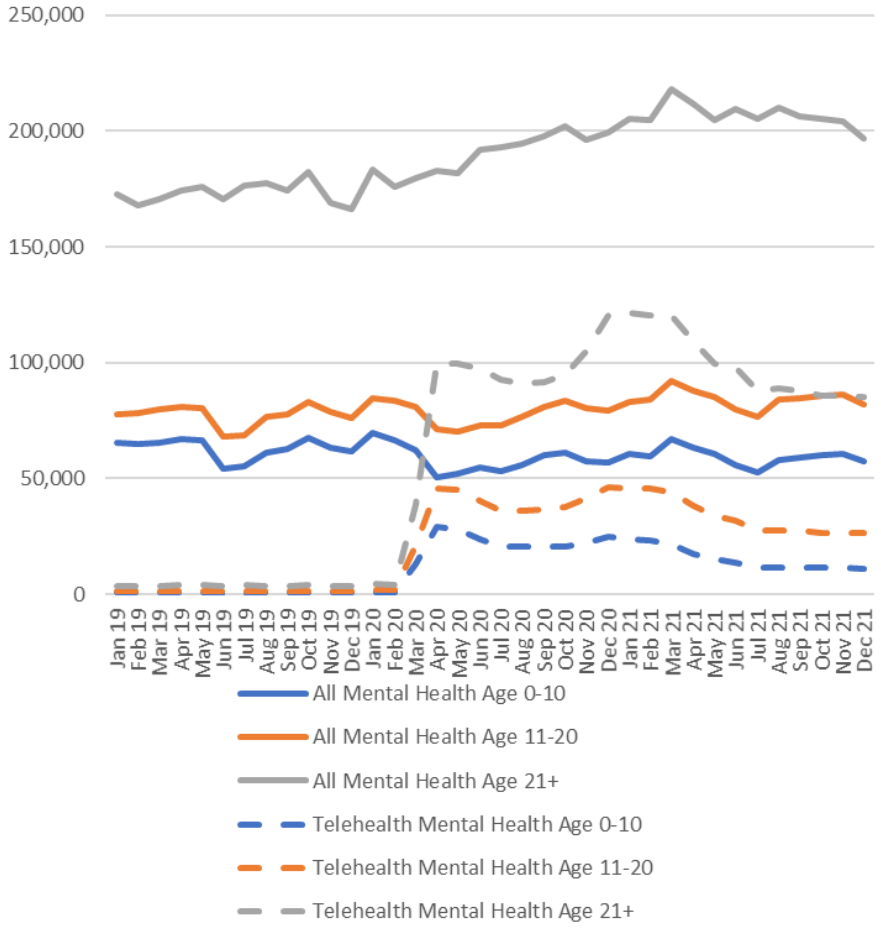


Medicaid Patient's Utilization of Telehealth Services
CMHC & SUD Clinic Claims Eligible for Telehealth

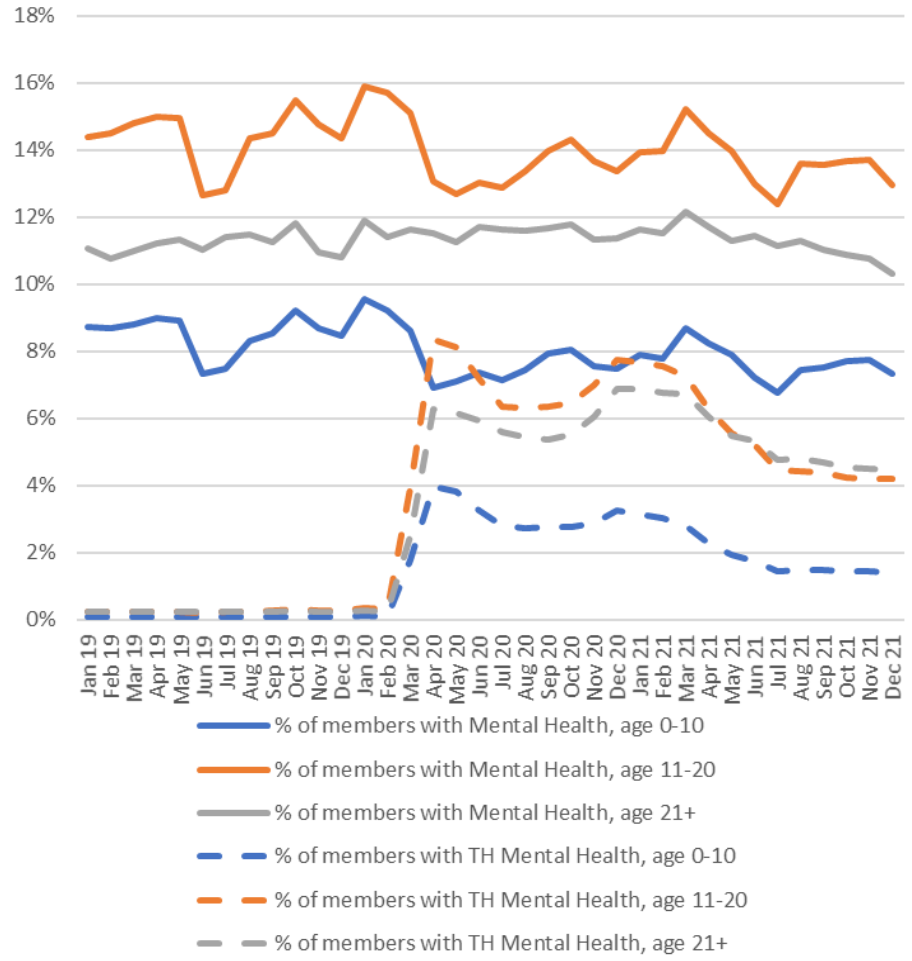


Medicaid Members Using Non-Acute/Non-Emergent Mental Health Services (Patient Counts) by Age Group with Telehealth Split Pre- and During-PHE

Patients



% Medicaid Members



The age group which has the highest rate of Medicaid members using non-acute/non-emergent MH services is 0-10. Note that the youth age groups have the most seasonal fluctuation both prior to and throughout the PHE.

Effectiveness of Telehealth for BH Services

Example: Near Real-Time Data Tracking

Telehealth usage climbed notably after Governor DeWine authorized emergency flexibilities during first year of the COVID pandemic.

Telehealth Trends

TOTAL RECIPIENTS

2020	2021
849,345	770,049

Physical Health Service Telehealth claims

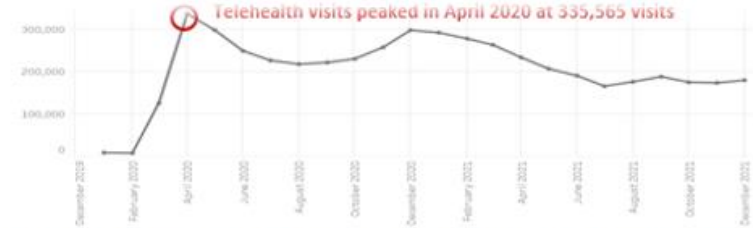
1,000	300,000
average claims per month before March 2020	claims made in April 2020

Mental Health and Addiction Service telehealth claims

4,000	270,000
average claims per month before March 2020	claims made in April 2020

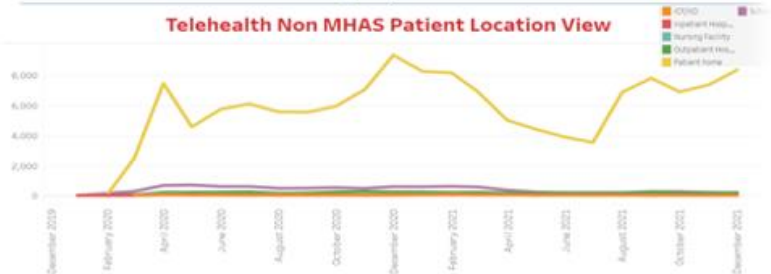
Billing requirements such as modifiers were not initially required during the PHE to ensure providers could successfully submit claims for payment resulting in a potential undercounting of telehealth claims

RECIPIENTS



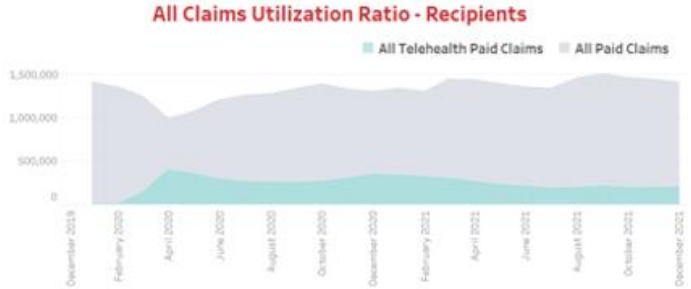
Early data shows telehealth use skyrocketed during initial months of the COVID-19 State of Emergency and has since leveled off.

PLACE OF SERVICE



A majority of patients sought care from their home. This data was not initially required to be reported and as such, is undercounted.

UTILIZATION RATIO



Virtual visits supported in person visits to prevent gaps in care throughout the PHE.

12

Technology as Conduit to Care:

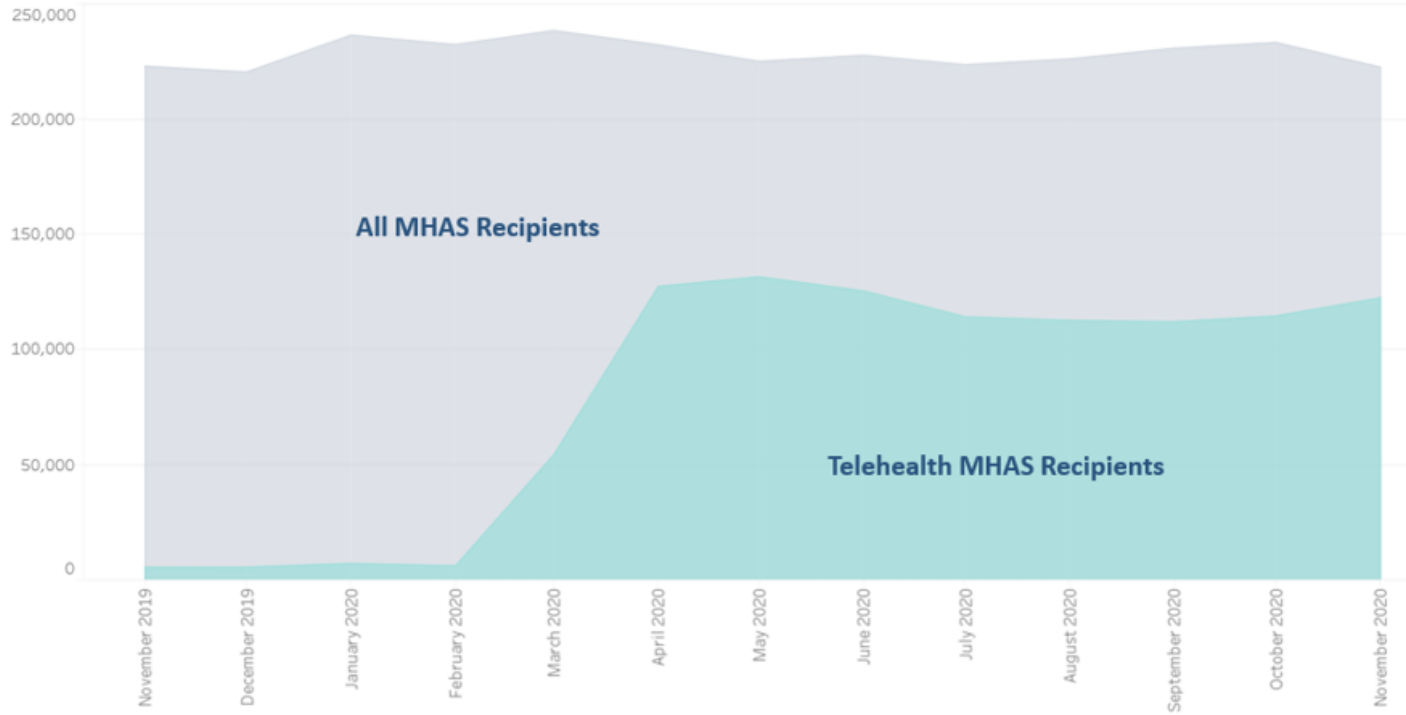
Telehealth Expansion During COVID-19

VISION: A regulatory framework that expands **clinically appropriate** telehealth services while maintaining the **fiscal sustainability** and **integrity** of Ohio's Medicaid program

GOALS

1. ***Maintain quality of care***
2. ***Enhanced access for patients***
3. ***Improved health outcomes***
4. ***Flexibility for providers and patients***

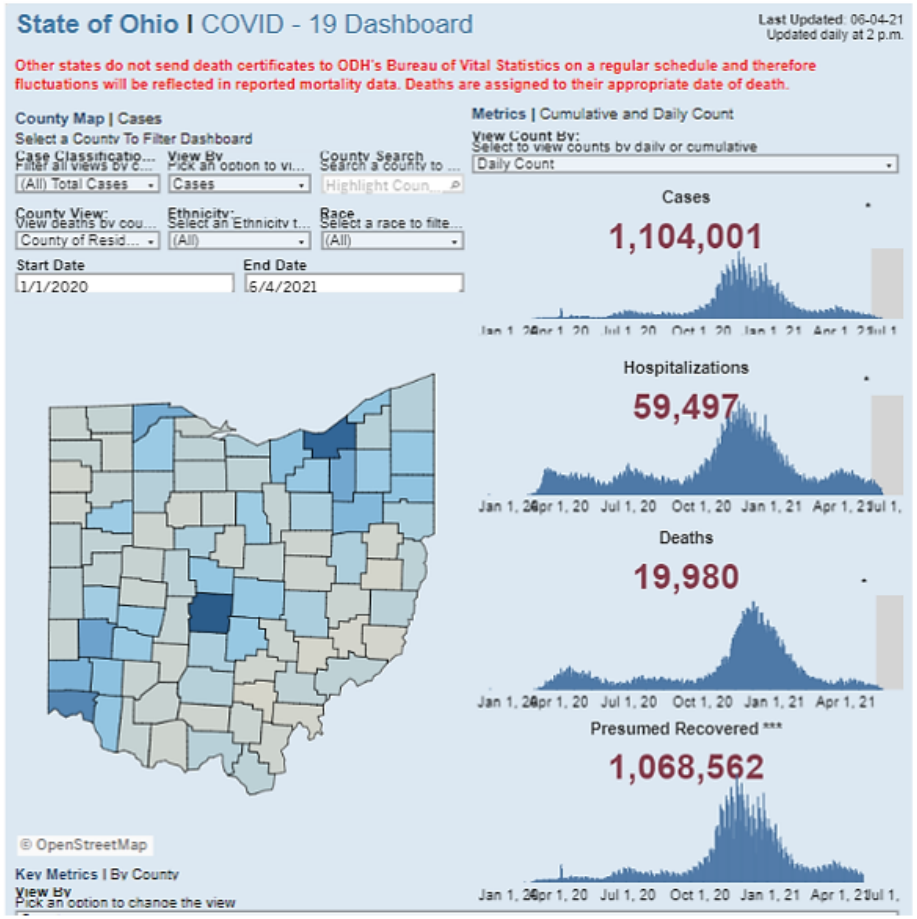
The Number of Medicaid Recipients receiving Telehealth Services through MHAS Providers (Nov 2019 – Nov 2020)



- Medicaid recipients receiving mental and behavioral health services remained steady through out the public health emergency (PHE).
- More than 50% of the Medicaid recipients received mental and behavioral health services via telehealth since the PHE.

Technology as Triage:

Data Reveals High-Risk COVID Populations



- Elderly and infirmed discovered to be at higher risk.
- State ability to monitor and report cases was fragmented.
- Speedy access to reliable data was imperative.
- ODM and ODH teamed to collect, confirm, and analyze cases, but at 50% match.
- A shared ODM/ODH dashboard was introduced to inform multiple stakeholders and develop lifesaving COVID policies, procedures, and partnerships for the high-risk group.
- Side benefit: early reporting forms with lighter data requirements encouraged facilities of all sorts to report cases, ensuring that the state received as much information as possible at a critical time of care.