Managed Care

- Managed Care is a health care delivery system organized to manage cost, utilization, and quality.
- Over 2.4 million Medicaid enrollees are served by the five statewide managed care plans (MCPs) (86% of the Medicaid Population)
- Ohio pays Managed Care Providers a fixed amount per Medicaid recipient, thus capping the total cost the state of Ohio pays for Medicaid health care services.
- The state of Ohio sets specific quality outcome measurements to hold Managed Care Providers accountable for quality care to its members.
What Is Different When Services Are Delivered By Managed Care Plans (MCPs)?

<table>
<thead>
<tr>
<th>FFS</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must search for a provider to accept Medicaid</td>
<td>Each member assigned a primary care provider (PCP); can change as needed</td>
</tr>
<tr>
<td>One Prior Authorization process</td>
<td>Prior Authorization process can vary by plan offering more flexibility</td>
</tr>
<tr>
<td>Any willing provider with Medicaid Provider ID #</td>
<td>Providers within the plan network for most services</td>
</tr>
<tr>
<td>Monthly Medicaid Paper Card</td>
<td>Permanent Member ID Card</td>
</tr>
<tr>
<td>No point of contact</td>
<td>MCP points of contact - member services, 24-hour nurse advice line, and care managers</td>
</tr>
<tr>
<td>Basic Medicaid benefit package</td>
<td>Basic Medicaid plus additional benefits</td>
</tr>
</tbody>
</table>
HCBS Waiver Services and Managed Care

- Starting 1.1.17 individuals with a DD waiver can voluntarily choose to receive Medicaid state plan services through an MCP and keep their waiver benefits.
- Removes need for members to disenroll from an MCP when they become eligible for a DD waiver.
- Adult extension members can also qualify for waiver services and maintain their MCP.
- Waiver Services are not impacted by someone enrolling in an MCP.
- Non-Waiver Services such as Private Duty Nursing, or Home Health, that often work in tandem with HCBS Waiver services, are available and will be reviewed individually for medical necessity as outlined in the Ohio Administrative Code (OAC).
Services In Managed Care Plans

- MCPs are required to cover state plan services

- MCPs may have limitations on the amount of a service, have different criteria for deciding whether you can receive a service, or have a prior authorization process that you must go through to receive a service.
Other Services in Managed Care

- MCPs also cover additional benefits
  - Permanent Member ID card
  - Incentive Programs
  - Enhanced vision and dental
  - Transportation
  - Call Center
  - 24/7 Nurse Advice Line
  - Care Coordination
  - Disease Management programs
  - Transition Plan to cover FFS benefits approved prior to managed care
Network and Other Considerations

- MCPs are required to demonstrate network capacity each quarter.
- The size of their network is based on the size of the MCP membership.
- Check networks for your medical professionals leveraging the MCPs online provider directories.
- Look at Medicaid Managed Care Report Card.
- Make sure you understand the voluntary enrollment and disenrollment process available to you.
Examples

- Modified Diet regarding pureed food and thickening agent
- Insulin Assistance from a Home Health Agency
Who are the MCPs?

The State of Ohio has contracted with 5 Managed Care Plans (MCPs). Each MCP is available to serve Ohioans in all 88 counties:

- CareSource
- Molina
- United HealthCare
- Paramount
- Buckeye

http://medicaid.ohio.gov/FOROHIOANS/Programs/ManagedCareforOhioans.aspx
How can individuals with DD waivers enroll in an MCP?

- Call the Medicaid Consumer Hotline at 1-800-324-8680
- Hotline staff can assist with enrollment selection
- [http://ohiomh.com](http://ohiomh.com)
- More info on managed care can be found at: [http://www.medicaid.ohio.gov/PROVIDERS/ManagedCare.aspx](http://www.medicaid.ohio.gov/PROVIDERS/ManagedCare.aspx)
Differences between Managed Care services and State Plan services.

Q: What is a Managed Care?

A: Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid Managed Care gives Ohio the opportunity to contract with Managed Care Providers (MCP) to enroll Medicaid recipients as members, into their company specific health care plan. Ohio pays the provider a set amount per Medicaid recipient, thus capping the total cost the state of Ohio pays for Medicaid health care services.

Q: How is my waiver affected when I enroll into Managed Care?

A: Your waiver will not be affected by enrolling in Managed Care. Your waiver services will continue to be planned and paid for by the local county board of developmental disabilities. The amount and kind of waiver services you receive is not affected by your choice to enroll into Managed Care.

Q: Will I get to go to the same doctors and specialists I have always gone to?

A: Each Managed Care Provider (MCP) has its own panel of medical providers that are covered by their company specific plan. Before you choose a Managed Care Provider (MCP), you should find out if your current professionals are in that Managed Care Provider's (MCP) network.

Q: Will I have all of the same services covered if I choose an MCP to manage my benefit?

A: Managed Care Providers are required to provide the same services that are covered in the State Plan Service. These services include, but are not limited to;

- Inpatient hospital services
- Outpatient hospital services (including those provided by rural health clinics & federally qualified health centers)
- Physician services
- Laboratory and x-ray services
- Screening, diagnosis, and treatment services for children under age 21, under Healthchek (EPSDT)
- Immunizations
- Family planning services and supplies
 ✓ Home health and private duty nursing services
 ✓ Podiatry
 ✓ Chiropractic services
 ✓ Physical, occupational, developmental, and speech therapy services
 ✓ Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services
 ✓ Prescription drugs
 ✓ Ambulance and ambulette services
 ✓ Dental services
 ✓ Durable medical equipment and medical supplies
 ✓ Vision care services, including eyeglasses
 ✓ Nursing facility services (limited to short-term rehabilitative stays for certain population groups)
 ✓ Hospice care
 ✓ Behavioral health services
 ✓ Respite services for eligible children receiving Supplemental Security Income (SSI)

It is important to note, that Managed Care Providers (MCP) may have limitations on the amount of a service, different criteria for deciding whether you can receive a service, or a prior authorization process that you must go through to receive a service. Your doctor or other medical provider should also be able to assist you in finding out these limits or how to request authorization for your medical services.

Q: What things should I consider before I enroll in a Managed Care plan?

A: Check to see if your current healthcare professionals are in the MCP network
If you are receiving State Plan nursing and/or home health services, find out what the MCP’s authorization process is for those services. Use online resources to look at the quality and outcome ratings for each provider.

2016 Ohio Managed Care Plans Report Card –

Q: What other services are provided if I enroll in a Managed Care plan?

There are additional services and supports that are NOT provided currently in State Plan Service. Managed Plans HAVE;

• Transportation to medical appointments (Physical or Behavioral) – 30 one way trips (15 round trips)
• A Call Center –
  o 24 Hour, 7 Days a Week Medical Advice Line
  o Customer Service Toll Free Number to ask about benefits
• Care Coordination – A case manager for your physical and behavioral health care needs
• **Transition Plan** – A process to assure a good transition between the State Plan Service and a Managed Care Provider

Q: If I enroll in Medicaid Managed Care, can I later voluntarily choose to go back the State Plan Services and disenroll from Managed Care?

A: Yes. Medicaid manage care is a true option for people with developmental disabilities, so a person may revert to their state plan services if they choose. Disenrollment from a managed care plan occurs the last day of the month no matter when the disenrollment process was initiated.

Q: Who are the providers that managed the state of Ohio’s Medicaid plan?

A: The five Managed Care Providers (MCP), contracted with the state of Ohio are:

1) Buckeye
2) CareSource
3) Molina
4) Paramount
5) UnitedHealth Care

The Ohio Department of Medicaid meets regularly with the 5 MCP’s to monitor the overall quality of the plans and their ability to meet the state’s expectations regarding quality and outcomes.

**Resource Links:**

See the 2016 Medicaid Annual Report -

Review the 2016 Ohio Managed Care Plans Report Card –

(Online) Medicaid Consumer Hotline
[http://ohiomh.com](http://ohiomh.com)
The Ohio Department of Medicaid wants to make you aware that you will have the option to enroll in a managed care plan to receive your Medicaid healthcare benefits and continue to receive your DD Waiver services as you do today.

To help coordinate your Medicaid health benefits, you may enroll in a Medicaid managed care plan. If you choose to enroll, the plan you select will provide your Medicaid healthcare benefits coverage, beginning January 1, 2017. You will get a letter from us in the next few weeks with instructions about how to choose a managed care plan. If you choose to enroll to have your healthcare services covered through a Medicaid managed care plan, you will continue to receive your waiver services, including waiver services coordination, through your local county board of developmental disabilities.

A managed care plan is a private health care insurance company, which works with the Ohio Department of Medicaid, to coordinate your healthcare, provide care management for healthcare services, and provide coverage for your health care needs.

Here are some of the benefits you will receive at no additional cost when you enroll in a managed care plan:

- A nurse advice line available 24 hours a day, 7 days a week, for help with your health care questions and concerns.
- A care manager to help you coordinate your medical care.
Some managed care plans may offer other services and benefits, such as:

- Transportation to medical and Medicaid renewal appointments.
- No or lower co-pays for prescriptions, dental services, routine eye examinations, eye glasses, and non-emergency services provided in a hospital emergency room.

Some frequently asked questions are enclosed with this notice. If you have additional questions please call the Ohio Medicaid Consumer Hotline at (800) 324-8680. Representatives are available Monday through Friday, 7 a.m. to 8 p.m. and Saturday 8 a.m. to 5 p.m. or visit www.ohiomh.com.

Sincerely,

[Signature]

John B. McCarthy
Director
Frequently Asked Questions about Managed Care:

1. I receive waiver services from the Ohio Department of Developmental Disabilities; do I have to enroll in a managed care plan?

   You are not required to enroll. You may enroll in a managed care plan if you choose. If you choose to enroll to have your healthcare services covered through a Medicaid managed care plan, your waiver services will not change. You will continue to receive your waiver services, including waiver services coordination, through your local county board of developmental disabilities.

2. I live in an intermediate care facility for individuals with intellectual disabilities, am I able to enroll in a managed care plan?

   No, you may not enroll in a managed care plan.

3. I receive waiver services from the Ohio Department of Developmental Disabilities, and I have Medicaid and Medicare; do I have to enroll in a MyCare Ohio plan?

   No, you may not enroll in a MyCare Ohio plan.

4. What will happen if I do not select a managed care plan?

   If you do not select a managed care plan, you will continue to receive a paper medical card every month like you do today.

5. When can I enroll?

   In a few weeks, you will receive a letter from the Ohio Department of Medicaid informing you that you may select a managed care plan. You will have five managed care plans from which to choose. This letter will also give you instructions on how to pick a plan and how to enroll. You will be able to enroll by phone, online, or by mail.

6. Will my benefits be different?

   Your managed care plan will include all benefits available through the traditional Medicaid program. You may also be eligible to receive added services that the traditional Medicaid program does not offer (for example, extra dental visits), depending on which managed care plan you choose. You will continue to receive your waiver services in the way you do today.

7. Is there any additional cost to enroll in a managed care plan?

   There is no additional cost with managed care. If you currently pay a patient liability, you will continue to pay it in the same way you do today.
Call Center

Customer Service Call Center

- The MCP must provide assistance to members through a member services toll-free call-in system.
- MCP member services staff must be available nationwide to provide assistance to members through the toll-free call-in system every Monday through Friday, at all times during the hours of 7:00 am to 7:00 pm Eastern Time, except for the following major holidays:
  - New Year’s Day
  - Martin Luther King’s Birthday
  - Memorial Day
  - Independence Day
  - Labor Day
  - Thanksgiving Day
  - Christmas Day

If a major holiday falls on a Saturday, the MCP member services line may be closed on the preceding Friday. If a major holiday falls on a Sunday, the member services line may be closed on the following Monday.

Medical Advice Call Center

- The MCP must also provide access to medical advice and direction through a centralized twenty-four-hour, seven day (24/7), toll-free call-in system, available nationwide.
- The 24/7 call-in system must be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPNs), and registered nurses (RNs).
- The MCP must meet the current American Accreditation HealthCare Commission/URAC-designed Health Call Center Standards (HCC) for call center abandonment rate, blockage rate and average speed of answer.
- At least semi-annually, the MCP must self-report its monthly and semi-annual performance in these three areas for their member services and 24/7 hour toll-free call-in systems to ODM as specified. If

ODM reserves the right to require more frequent reporting by a MCP if it becomes aware of an egregious access issue or consecutive months of non-compliance with URAC standards.
Care Coordination

OAC 5101:3-26-03.1

Applicable Managed health Care Programs (MCP) Care Coordination responsibilities;

- Ensure that each member has a primary care provider who will serve as an ongoing source of primary care and assist with care coordination appropriate to the member’s needs;
- Provide for a second opinion from a qualified health care professional within the MCP’s panel, upon request from the member;
- Share specific information with non-panel providers designated by the department of job and family services;
- Provide a centralized toll-free call-in system to provide members with medical advice and direct members to the appropriate care setting;
  - Have services available to assist hearing impaired members and LEP members to use the call-in system;
- Have a utilization management program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member;
- Provide care management services to coordinate and monitor treatment rendered to members with specific diagnoses or who require high-cost or extensive services;
- Development, implementation, and ongoing monitoring of a care treatment plan for members in care management.

Connecting Points, and Alignment of Services

- Prior Authorization of Medical or Behavioral Health treatment
- Transitions of Medical or Behavioral Health treatment
- Individual Care Plans (ICP) can help inform the Individual Service Plan (ISP)
- Care Quality Issues, or Health Network deficiencies
- Annual assessments or updates completed, either together, or by sharing information
- Monitor of prescribed treatment follow up by HCBS waiver providers (medication, specialist appointments, etc.)
- Sharing of Medical Claims data, triggered by Urgent Care or Emergency Care intake
Transition Planning

Post Enrollment Transition Coverage Grid

- The MCP must allow a new member who is transitioning from FFS to an MCP to continue to receive services from network and out-of-network providers as per the following:

<table>
<thead>
<tr>
<th>Transition Requirements</th>
<th>≥ 21</th>
<th>&lt; 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>Must allow the member to continue with out of network physician or specialist for the first month of enrollment.</td>
<td>Must allow the member to continue with out of network physician or specialist for the first three months of enrollment.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Honor Medicaid FFS prior authorizations (PAs) for no less than 90 days from the enrollment effective date.</td>
<td>Honor Medicaid FFS prior authorizations (PAs) for no less than 90 days from the enrollment effective date.</td>
</tr>
<tr>
<td></td>
<td>The MCP must honor the Medicaid FFS PA for 90 days or the duration of the PA, whichever is longer, for the following items: enteral feeding supply kits, hearing aids, synthesized speech generating devices, and parenteral nutritional supply kits.</td>
<td></td>
</tr>
<tr>
<td>Home Care and Private Duty Nursing</td>
<td>Maintain current service level with current provider until the MCP conducts a medical necessity review.</td>
<td>After 90 days of enrollment and prior to transitioning to a participating provider or proposing a change in the service amount, the MCP must make a home visit, and observe the home care or PDN service being provided, to assess the current need for continued services.</td>
</tr>
<tr>
<td>Transition Requirements</td>
<td>≥ 21</td>
<td>&lt; 21</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>The MCO must cover prescription refills during the <strong>first three months</strong> of membership for prescriptions covered by Ohio Medicaid during the prior FFS enrollment period.</td>
<td>Thereafter, the MCP may require prior authorization have providing education for the member to that effect. If applicable, the MCP must offer the member the option of using an alternative medication that may be available without prior authorization.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Honor Medicaid FFS prior authorizations (PAs) for no less than 90 days from the enrollment effective date.</td>
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</tr>
<tr>
<td>Scheduled Surgeries</td>
<td>Must allow the member to receive scheduled inpatient or outpatient surgery if it has been prior approved and/or pre-certified.</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy or Radiation</td>
<td>Must allow the member to continue to receive the entire course of treatment if initiated prior to enrollment with the MCP.</td>
<td></td>
</tr>
<tr>
<td>Organ, Bone Marrow, Hematopoietic Stem Cell Transplants</td>
<td>Must honor current FFS prior authorizations for organ, bone marrow, or hematopoietic stem cell transplant.</td>
<td></td>
</tr>
<tr>
<td>Vision and Dental</td>
<td>Must honor current FFS prior authorizations for any vision and dental services that have not yet been received.</td>
<td></td>
</tr>
<tr>
<td>Hospital Discharge</td>
<td>Must continue with treatment if the member was discharged 30 days prior to the MCP enrollment effective date.</td>
<td></td>
</tr>
<tr>
<td>Pregnancy Care</td>
<td>Must allow a member who is in her third trimester of pregnancy to continue a relationship with her out of network obstetrician and/or delivery hospital.</td>
<td></td>
</tr>
</tbody>
</table>
Transportation

Transportation Standards

✓ 30 one way trips per calendar year
✓ MCPs must ensure transportation pick-up is completed not more than fifteen (15) minutes before or fifteen (15) minutes after the pre-scheduled pick-up time, ensuring the member is on time for their appointment, and no more than thirty (30) minutes after a request for pick-up following a scheduled appointment.
✓ The vendor must attempt to contact the member if he/she does not respond at pick-up.
✓ The vendor must not leave the pick-up location prior to the pre-scheduled pick-up time.
✓ The MCPs must identify and accommodate the special transportation assistance needs of their members (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements). Member-specific needs must be communicated to the transportation vendor and updated as frequently as is needed to support the member’s needs. Where applicable, these needs must be documented in the member’s care plan.
✓ A care provider and/or children may be provided transportation to an appointment, alongside the member.

The MCP is required to make transportation available to any member requesting transportation when the member must travel thirty (30) miles or more from his or her home to receive a medically-necessary Medicaid-covered service provided by the MCP pursuant to OAC rule 5160-26-03 and Appendix G of the Managed Care Provider Agreement. These trips do not count toward the 30 one way trips per calendar year that are covered for trips less than 30 miles from home.

Weather Emergencies

MCPs must submit a plan for the provision of transportation services during winter snow and other weather emergencies, specifying the transportation of consumers requiring critical services, notification to consumers of canceled transportation and rescheduling.

The plan must specify the snow emergency level and any other weather-related criteria that require a change to scheduled transportation.
Comparing Ohio Medicaid Managed Care Plans

Your health care is important. Choosing the managed care plan that works best for you and your family is also important. One thing to think about before you decide is how well the different plans provide care and services. This report card shows how Ohio Medicaid’s managed care plans compare to one another in key performance areas. The ratings for each area summarize plan performance on a number of related standards.

<table>
<thead>
<tr>
<th>Performance Areas</th>
<th>Buckeye Health Plan</th>
<th>CareSource</th>
<th>Molina Healthcare</th>
<th>Paramount Advantage</th>
<th>UnitedHealthcare Community Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Care</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
</tr>
<tr>
<td>Doctors’ Communication and Service</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
</tr>
<tr>
<td>Keeping Kids Healthy</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
</tr>
<tr>
<td>Living with Illness</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
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</tr>
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</table>

The information used for this report was collected from the managed care plans and their members and was reviewed for accuracy by independent organizations. The most current information available was used for this report (Data Source: National Committee for Quality Assurance [NCQA] Healthcare Effectiveness Data and Information Set [HEDIS®] & Consumer Assessment of Healthcare Providers and Systems [CAHPS®] 2016). CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

What is Measured in Each Performance Area?

Ohio Medicaid evaluates each plan on the following:

**Getting Care**
- How well the plan provides members with access to care
- If members report they can get the care they need, when they need it

**Doctors’ Communication and Service**
- How happy members are with their doctors
- If members feel their doctors communicate well
- If members report their doctors involve them in decisions about their care

**Keeping Kids Healthy**
- If children receive care needed to stay healthy, such as immunizations, well-child visits, and dental visits

**Living with Illness**
- How well the plan provides care and services to help people manage illnesses, such as diabetes, high blood pressure, asthma, and depression

**Women's Health**
- If women receive tests that screen for female cancers and diseases
- If women receive care before and after their babies are born
Choosing a Medicaid Managed Care Plan

There are many things to think about when choosing a plan for you and your family. Here are some questions to ask yourself before you pick a plan:

» Which plans have all or most of the doctors and hospitals my family and I visit?

» Which plans have doctors with office hours and locations that are convenient for my family and me?

» Which plans offer extra services that I need or want (like health and wellness programs, extra help for pregnant women, and more transportation choices)?

» How do the plans cover my medications?

» How well did the plans perform in each section of this report card?

You may have other questions or concerns that are important to you. You can contact the plans using the information below. They can tell you which providers and extra services they offer. You can also use the Medicaid Provider Search tool at www.ohiomh.com to find out which providers each plan offers.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buckeye Health Plan</td>
<td>1-866-246-4358</td>
<td><a href="http://www.buckeyehealthplan.com">www.buckeyehealthplan.com</a></td>
</tr>
<tr>
<td>CareSource</td>
<td>1-800-488-0134</td>
<td><a href="http://www.caresource.com">www.caresource.com</a></td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>1-800-642-4168</td>
<td><a href="http://www.molinahealthcare.com">www.molinahealthcare.com</a></td>
</tr>
<tr>
<td>Paramount Advantage</td>
<td>1-800-462-3589</td>
<td><a href="http://www.paramountadvantage.org">www.paramountadvantage.org</a></td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td>1-800-895-2017</td>
<td><a href="http://www.uhccommunityplan.com">www.uhccommunityplan.com</a></td>
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Information as of June 2016

Learn More:
Visit the Ohio Department of Medicaid online: www.medicaid.ohio.gov
Call the Ohio Medicaid Consumer Hotline toll-free: 1-800-324-8680
or go online: www.ohiomh.com

The Ohio Department of Medicaid is an equal opportunity employer and service provider.
Managed Care Enrollment for Children in Custody and Adopted Children
Introduction

• Medicaid is Ohio’s largest health payer delivering services for nearly 3 million individuals insured by Medicaid

• Over 2.4 million Medicaid enrollees are served by the five statewide managed care plans (MCPs) (86% of the Medicaid Population)
  » Buckeye
  » CareSource
  » Molina Healthcare of Ohio
  » Paramount Advantage
  » UnitedHealthcare

• All managed care plans are statewide
New Populations
• Ohio moving towards all managed care state
• Several populations being added.

<table>
<thead>
<tr>
<th>Population/Service</th>
<th>Managed Care Transition Date</th>
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<tr>
<td>Adult Extension members with HCBS Waiver</td>
<td>August 2016</td>
</tr>
<tr>
<td>Individuals enrolled in the BCMH program</td>
<td>January 2017</td>
</tr>
<tr>
<td>Children in Custody/Adoption</td>
<td>January 2017</td>
</tr>
<tr>
<td>BCCP</td>
<td>January 2017</td>
</tr>
<tr>
<td>Individual enrolled on a DD waiver</td>
<td>Voluntary January 2017</td>
</tr>
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</table>
Benefits of Managed Care

• Access to care, providers, PCP (can change at any time)
• Permanent Member ID Card with Medicaid ID
• One point of accountability
• Care management
• Enhanced benefits (dental/vision/transportation)
• Member interaction – member services line, 24-hour nurse line
• Care coordination
• Health and Wellness programs
• Improved Health Outcomes
• Targeted improvement efforts to state priorities

Better coordination = Better health outcomes
What is different when services are delivered by Managed Care Plans (MCPs)?

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ODM Monitoring and Oversight of Managed Care Plans

• Provider agreement with each MCP
• ODM staff designated solely to oversight of MCPs
• Contract requirements / point system & fines
• Member Complaints
• Provider Panel Requirements and Access
• Care management requirements
• Grievances, Appeals and State Hearings process
• Prior Authorization timeline requirements
• Performance and quality improvement through consumer surveys, quarterly and annual reviews, MCP report cards, and other federal monitoring and reporting requirements.
Decisions to Date

• Transition of care requirements when transitioning from FFS to Managed Care
• Extending hands-on care management to ensure all are receiving needed services.
• Data provided to MCPs to ensure provider network
• 2 years of FFS claims history will be provided to MCPs for each member
• Children whose official residence is out of state will not be eligible for managed care enrollment; those residing in state but receiving some services out of state will enroll in managed care
Adoptive Children in Managed Care

Families of adopted children will receive 1st ODM notice telling them they will need to select an MCP for their child(ren)

Adoptive parents may call the Medicaid Consumer Hotline to get assistance selecting a plan or visit www.ohiomh.com

Time to select an MCP!
2nd ODM Letter will be sent telling parents its time to enroll!

If the adoptive parent does not make a decision, ODM will select a plan on their behalf

Enrollment Begins!
Child(ren) successfully enrolled with MCP – 90 days to change plan or during open enrollment annually in November

Late October

Mid November

January 2017

• To select a Managed Care Plan:
  » Call the Medicaid Consumer Hotline: 1-800-324-8680 or [http://ohiomh.com](http://ohiomh.com)
  » Hotline staff can help members review providers in each plans’ network to assist in selection
  » MCP Member ID cards will be sent to adoptive parents
Children in Custody in Managed Care Pilot

- ODM, pilot PCSAs, MCPs, and PCSAO will identify lesson learned and areas of opportunity and adjust the enrollment schedule as need.
## Children in Custody in Managed Care

<table>
<thead>
<tr>
<th>Time to select an MCP!</th>
<th>Children identified by the PCSAs for a November 1 enrollment will be enrolled effective January 1.</th>
<th>Children identified by the PCSAs for a January 1 enrollment will be enrolled effective February 1.</th>
<th>MCPs will reach out to the PCSA to initiate care coordination/needs assessments for children as they enroll.</th>
<th>Children in custody can change plans at anytime with enrollment in new plan beginning the next effective month.</th>
</tr>
</thead>
</table>

### September

- PCSAs will have a single point of contact for each MCP.

### November 2016 – February 2017


### March 2017

- Medicaid cards will be sent to the PCSA unless otherwise designated by county worker.
Enrollment Spreadsheets

• Submission status
• Next steps
• Missing Spreadsheets (?)
MAKING OHIO BETTER
Coordinating Services & Managing Care
Covered Benefits and Services
Ohio Medicaid Managed Care Benefits

• The following includes but is not limited to a general list of the benefits covered by Medicaid and MCPs:
  ✓ Inpatient hospital services
  ✓ Outpatient hospital services (including those provided by rural health clinics & federally qualified health centers)
  ✓ Physician services
  ✓ Laboratory and x-ray services
  ✓ Prescriptions
  ✓ Dental
  ✓ Vision
  ✓ Durable Medical Equipment (DME)

http://medicaid.ohio.gov/PROVIDERS/ManagedCare.aspx
Value Added Benefits

- Additional transportation benefits
- Statewide Network of Providers
- 24-Hour Nurse Advice Line
- Care Management

- Enhanced Dental and Vision Coverage
- Self-Service Capabilities
- Disease Management and Health Education Programs
- Member services line
Need a Provider?

Each MCP has an on-line provider directory
• ① Go to MCP website
• ② Search by provider name, provider type, and location, including distance from where you live.

Call the MCP’s Member Services – phone number will be on member ID card.

Go to http://ohiomh.com to find which MCPs contract with a provider
• ① Use the Search Tools to find a Medicaid provider
• ② Search by provider name, provider type, and location, including distance from where you live.

Call the Medicaid Hotline at 1-800-324-8680
Behavioral Health Providers

- Ohio Department of Mental Health and Addiction Services’ Providers
  - Not contracted with MCPs – can go to any of these providers
  - Will not see these individual providers on provider searches
  - Still present MCP member ID card when going to providers
  - MCP responsible for covering prescriptions written by providers at a plan network pharmacy
  - MCP responsible for coordinating these services
Care Management Overview
Goals of Care Management

• Focus on improving member outcomes and quality of life
• Minimize/eliminate barriers to care
• Creating efficiencies
• Collaborate with community providers to decrease higher cost care such as emergency room utilization and inpatient stays
• Improve utilization of appropriate health resources (i.e. linkage to preventive health resources, primary care, specialists, dentists, behavioral health, etc.)
Care Management Team

- Care Managers may be registered nurses, social workers, counselors, or LPNs

- CM team may interact with members or the child’s parent/guardian (community health workers, member services, outreach specialists)
What do Care Managers Do?

- Outreach to members or parent/guardian either in person, or telephonically who are identified as having safety, behavioral, medical or social issues.
- Assess member’s needs, barriers, and gaps in care.
- Create a care plan with member or parent/guardian and Care Team that outlines problems, goals and needed interventions - emphasizing safety and social needs.
- Secure community resources and provide guidance to improve member’s health and well-being.
- Encourage member or parent/guardian to attend all doctor visits and take care of their health needs.
- Educate on plan benefits and services (i.e. nurse advice line, transportation).
Care Management Services

• Finding and referring to qualified healthcare providers
• Coordinating transportation to medical appointments
• Identifying and accessing covered benefits, and value-add benefits
• Providing care coordination
• Focus on transitions of care
• Monitoring provider quality
• Answering any questions about health insurance plan or coverage
Service Authorizations and Transition of Care
Service Authorizations/Utilization Management (UM)

- Definition of Utilization Management
- Authorizations
- Authorization Process
- MCPs want the Right Care at Right Time for improved health outcomes
- National Guidelines/Criteria
- Turn Around Times
- TOC as required by ODM
Pharmacy Authorization/Utilization Management

Standard Pharmacy Guidelines:
- Medicaid Requirements
  - PA list is standardized
  - Transition of Care rules apply
  - Antidepressant/Antipsychotic guidelines
- Managed Care Practices/Authorization Process
  - Standard PA form
  - Based on quality care, safety guidelines
Transition of Care

Accessing & Authorizing services:

• Identify member needs (data, assessments, member/provider outreach, etc.)
• Assure minimal disruption
  • Honor existing Medicaid authorized services
  • Out of network providers for time period
• Facilitate needed services
• Prevent care gaps or duplication of services
Appeals and Grievances
Denials

• Denials are issued when MCP is unable to approve a request for services. Examples are inpatient admit/continued stay, outpatient procedure, diagnostic test (MRI), pharmacy

• MCP’s will send in writing notification if we make a decision to:
  • Deny a request to cover a service
  • Reduce, suspend or stop services before you receive all the services that were approved or:
  • Deny payment for a service you received that is not covered by Medicaid
• If a member does not agree with a decision they can request an appeal with the MCP. The members provider may also initiate an appeal if they have been designated as the member’s authorized representative.

• Appeals can be requested by calling MCP, in writing, completing form online, in person or by fax.

• Appeals must be initiated within 90 calendar days from the day following the mailing date of the notice.

• Expedited Appeal/urgent requests- decision completed no later than 72 hours after appeal request.

• All other appeals – decision within 15 calendar days.
Grievances

• If a member is unhappy with MCP service or an MCP provider and notifies the plan this is a grievance

• Grievances can be completed by calling the MCP, completing the form online, by fax or mail.

• Time frame for response/outcome:
  • 2 working days for grievances related to not being able to get medical care/access to care
  • 30 calendar days for most other grievances except for billing issues which are 60 days.
Assistance

MCPs have many staff designated solely to assisting members with questions or resolving problems:

• Member services
• 24-hour nurse advice line
• Care managers

If MCP can’t assist:

• contact the Medicaid Hotline at 1-800-324-8680
Information Sharing
How Do Community Agencies and Managed Care Plans Work Together?

• **Connect** consumers with EACH OTHER and **share information** about our consumers needs, wants and aspirations.

• **Find and refer** consumers to qualified healthcare providers

• **Contact** MCO for copies of ID cards, member handbooks, etc.

• **Help consumers identify and access** covered and value-added benefits, including medical services, medications, transportation to medical appointments, and MCO programs that give rewards for good health.

• **Refer** consumers to MCO’s care coordination when it’s needed.

• **Participate and give feedback** to MCO’s and our Member Advisory Councils.

• **Work with MCO’s to improve provider quality** by monitoring and giving them tools and training to improve their performance
What is HIPAA and Why is it Important?

• Ohio Medicaid Managed Care Plans (Health Plans) are required to comply with the Health Insurance Portability and Accountability Act (HIPAA), a federal law that requires the protection of Beneficiaries’ Protected Health Information (PHI).

• HIPAA allows Health Plans to disclose PHI to individuals with certain permissions, as designated by the Beneficiary, or an individual with legal authority to act on their behalf.
PCSA Designations for Children in Custody

• Designate with the child’s Health Plan a substitute caregiver’s authority to only receive Protected Health Information (PHI) for a child in their care; or

• Designate with the child’s Health Plan a substitute caregiver’s authority to make decisions on behalf of a child in their care.
  • The PCSA is able to document whether there are limitations to the substitute caregiver’s decision-making authority. Substitute caregivers who have any degree of decision-making authority are automatically able to receive the child’s protected health information, as well.

• Only steps needed to designate appropriate authority
Step 1 – Identify Substitute Caregiver in SACWIS

• In the “Authorized Representative” field, identity the substitute caregiver and indicate the relationship. The following options are available:
  • Placement
  • Children Services/Court/ODYS worker
  • Relative
  • Other

• The MCP will receive this information prior to the child’s effective date, so that if the substitute caregiver calls the MCP, the substitute caregiver can, at a minimum, discuss the child’s protected health information with the Health Plan.
Step 2 – Designate Appropriate Authority

- This step requires the PCSA to share existing documents that PCSAs may already use to establish relationships with and any decision-making authority delegated to substitute caregivers.

Option 1 - To designate a substitute caregiver to **only** discuss protected health information on behalf of a child in their care - Complete and send to the child’s Health Plan a signed “Authorization for the Use and Disclosure of Protected Health Information (PHI)” form.

Option 2 - To designate authority for a substitute caregiver to make healthcare decisions on behalf of a child in their care - Send any, already existing, signed, consent documents used by the PCSA which establish the substitute caregiver’s legal status to take the child to the doctor and/or have other responsibilities related to the child’s healthcare.

Option 3 - To designate authority for a substitute caregiver to make **limited** healthcare decisions on behalf of a child in their care – Send any, already existing, signed, consent documents used by the PCSA which establish the substitute caregiver’s legal status to take the child to the doctor and/or have other responsibilities related to the child’s healthcare, *which explains the limitations.* **ALSO** complete and send an Authorization for Use and Disclosure form. Submitting both documents will ensure the foster parent is able to a) act on behalf of the child within a limited scope, and b) receive all of the child’s PHI, even if they are not able to make decisions about major surgeries and other healthcare-related matters.
How To Contact Us
Central and Primary contact:
Christine Haydock, Director Care Management
chaydock@centene.com
866-246-4356, ext. 24271
Cell: 419-481-5319

Regional contacts:
Northwest Region:
  Danielle Bradley, Supervisor, Care Management
dbradley@centene.com
  866-246-4356, ext. 24209
  Cell: 419-304-6213

Southwest Region:
  Lisa Robinette, Supervisor, Care Management
lrobinette@centene.com
  866-246-4356 ext. 24557
  Cell: 513-748-9790

NE Region:
  Karen Brophy, Supervisor, Care Management
kbrophy@centene.com
  866-246-4356 ext. 24313
  Cell: 330-255-1313
Primary PCSA Contacts:

Trisha Delong
tricia.delong@caresource.com
937-531-2917

Ashley Shepard
Ashley.shepard@caresource.com
937-531-2667

CareSource Member Services:
Ohio Member Services: 1-800-488-0134 (TTY: 1-800-750-0750 or 711)
Ohio Provider Services: 1-800-488-0134

A Member Services representative will be happy to answer your questions Monday through Friday, 7 a.m. to 7 p.m. unless otherwise stated below. Our Provider Services department will answer your calls from 8 a.m. to 6 p.m., Monday through Friday.
www.caresource.com
Primary Contact:
   Deidre Palmer, LPC, LSW, Supervisor for Healthcare Services
   800-357-0146, ext. 216341
   Deidre.Palmer@MolinaHealthcare.com

Molina’s Care Management Staff:
   8 a.m. to 5 p.m. Monday through Friday: 1-800-642-4168, extension 752117.

Molina’s Nurse Advice Line:
   1-888-275-8750
   After hours, on weekends, and holidays, the Molina Nurse Advice Line is able to:
   • Triage urgent medical issues include redirecting to appropriate level care setting,
   • Provide local information for crisis response in Ohio,
   • Perform override medication emergencies in our Caremark system after hour if called by the member, guardian, caregiver or provider of the member.
Northern Region Contact (Toledo/Lima/Maumee/Cleveland)
  Julie Hoskins RN, Manager Case Management
  Julie.hoskins@promedica.org
  419-887-2220

Southern Region Contact (Columbus/Dayton/Cincinnati/SE Ohio)
  Amy Baldridge RN, Director of Care Management
  (Southern Region)
  Amy.baldridge@promedica.org
  419-887-2400 (office)
  859-630-2137 (cell)
Primary Contact:
Jodi Blacksher
Jodi.blacksher@uhc.com or onmywayohioquestions@uhc.com
614-397-2947

UnitedHealthcare Member Services/Care Management Questions:
7 a.m. to 7 p.m. Monday through Friday: 1-800-895-2017 ext. 6, 7 or 8
24/7 Nurse Line: 1-800-542-8630