Managed Care 101

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Topics to Discuss

• Managed Care Fundamentals
• Medicaid Managed Care
• Characteristics of LTSS 2012
• Medicare Advantage Plans
• Integrated Care Delivery System
National and State Environment

• “Stampede” to Medicaid managed care-medical & BH
• Increasing use with more vulnerable populations
• Integrated systems for MMEs
• Health homes and other care coordination initiatives
• Payment reform is the goal
Terminology

• Medicaid managed care: medical and behavioral health care services
  – Fee for Service
  – Managed care
  – With or without “carve outs”

• Managed LTSS
  – Only LTSS
  – All or most Medicaid services, physical, behavioral and LTSS
  – Also including Medicare
Managed Care Fundamentals

• Both a service delivery structure and a financing arrangement.

• Goal is generally to reduce cost while coordinating and improving care.

• Several types of managed care organizations (MCOs):
  – Health maintenance organizations (HMOs), preferred provider organizations (PPOs), special needs plans (SNPs), primary care case management (PCCM), prepaid health plans (PHPs), etc.
  – We will be talking about Medicaid and Medicare managed care, but there is a private managed care industry, too.
Medicaid Managed Care
A Word About Fee-for-Service

- Historically, states structured their Medicaid programs as fee-for-service (FFS) delivery systems.
- FFS system often regarded as rewarding quantity over quality, because basic structure pays providers for each unit of service, with a financial incentive to increase number of units delivered.
- FFS also often criticized for inability to adequately coordinate care of high-risk consumers because consumers can go to any providers they choose.
- Desire for payment reform and better coordination of services is driving move to managed care.
Medicaid Managed Care Characteristics

• Defined network of providers; access.

• Traditionally, some element of “risk” – the MCO agrees to deliver or coordinate delivery of services (physical and/or behavioral health and/or long-term services and supports) for a fixed payment.
  – If the MCO delivers or coordinates delivery of services that cost less than the payment, it makes money. If the MCO delivers or coordinates delivery of services that cost more than the payment, it loses money.
  – Not all MCOs take on risk or take on all risk.

• Actuarial soundness of rates.
Medicaid Managed Care Characteristics (cont’d)

• Process
  – Procurement
  – Readiness review
  – Ongoing monitoring; data reporting, review of complaints/denials, etc.
Originally used widely in Medicaid with healthy moms and kids.

Managed care meets…
  – Physical health
  – Behavioral health
  – Aging and long term services and supports

Men Are from Mars, Women Are from Venus.

CROSS CULTURAL.
Regulating Medicaid Managed Care

• State Medicaid authorities develop their own standards of participation that include:
  – Protocols for enrollment and member support,
  – Requirements to ensure adequate access to care,
  – Benchmarks for quality and quality improvement, and data collection requirements.

• Section 1932(c) of the Social Security Act requires states operating Medicaid managed care programs to contract with an external quality review organization.

• Most state insurance regulations also govern Medicaid managed care organizations.
Medicaid Managed Care
By the Numbers

• 23 million people (40% of Medicaid population) enrolled in MCOs and another 13 million (22%) enrolled in PCCMs.

• As of 2011, Medicaid MCOs coordinate the health care of 1.6 million Ohioans.
• **Risk Based MCOs**
  – State contracts with MCOs to provide a defined package of benefits to enrolled Medicaid consumers.
  – State pays MCO a per member per month (PMPM)/capitated fee.
  – Responsible for coordinating the care of enrollees and must manage the cost of care and all administrative expenses within the PMPM.
  – Financial incentives put a premium on providing preventive or primary care to reduce the use of more expensive services.
  – Some argue that capitated arrangements provide an incentive to deny needed care.
  – Medicaid MCOs may be commercial HMOs that also serve people with employer-sponsored insurance, or they may be Medicaid-only plans with no commercially insured members.
Types of Medicaid Managed Care (cont’d)

- **Primary Care Case Management**
  - State contracts with primary care providers (PCPs) that agree to provide case management to Medicaid enrollees assigned to them, including coordination and monitoring of primary health care.
  - PCPs usually paid monthly fee to provide case management + FFS for the other health care services they provide.
  - State usually assumes full financial risk for the utilization of health care services.

- **Prepaid Health Plans**
  - PHPs provide either comprehensive or noncomprehensive benefits.
  - MCOs = comprehensive type of PHP.
  - Prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs) = noncomprehensive PHPs.
# Medicaid Managed Care Authorities

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<thead>
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</thead>
<tbody>
<tr>
<td><strong>1932 State Plan Option</strong></td>
<td>Either</td>
<td>Either</td>
<td>Either</td>
<td>Selective contracting allowed</td>
<td>Enrollment must be voluntary for certain children with special needs, MMEs, and Native Americans</td>
<td>21 states, including Ohio</td>
</tr>
<tr>
<td><strong>1915(a) Voluntary Contracting</strong></td>
<td>Voluntary</td>
<td>Either</td>
<td>Either</td>
<td>Selective contracting prohibited</td>
<td>Allows the state to offer a unique benefit package to specific populations</td>
<td>13 states</td>
</tr>
<tr>
<td><strong>1915(b) Waiver</strong></td>
<td>Either; can mandate enrollment of MMEs and other aged, blind, and disabled populations</td>
<td>Either</td>
<td>Can target</td>
<td>Selective contracting allowed</td>
<td></td>
<td>48 waivers in 28 states</td>
</tr>
<tr>
<td><strong>1915(b)/(c) Waivers</strong></td>
<td>Either; can mandate enrollment of MMEs and other aged, blind, and disabled populations</td>
<td>Either</td>
<td>Can target</td>
<td>Selective contracting allowed</td>
<td>Used to implement a mandatory managed care program that includes home and community-based waiver services; <strong>this is what the ICDS will be</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1115 Waiver</strong></td>
<td>Either</td>
<td>Either</td>
<td>Can target</td>
<td>Selective contracting allowed</td>
<td>Requires budget neutrality</td>
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</table>
Medicaid Managed Care in Ohio

Medicaid Care Coordination Plans serve as a health care home for 1.6 million Ohioans.

- 7 OAHP member companies serve enrollees throughout Ohio.
- Adding value for consumers and the state by serving as the health care home for members, coordinating the medical, behavioral and social service needs to keep people’s lives on track.
- $1 billion fiscal benefit to the state in the current biennium.
- Access to advice from nursing staff via a toll-free hotline, anytime, any place.
- Expanded provider networks.
- No co-pays.
- Transportation services to appointments.
- Incentives for members to maintain good health.
- 97% of claims paid within 30 days and 99.8% of clean claims paid within 90 days according to the most recent ODJFS Managed Care Prompt Pay Semi-Annual Report for 2010.
- 88% of children age 12 months to 11 years in the Medicaid Care Coordination Program had a primary care visit; 86% of children ages 12-19 had a primary care visit during the same period; and Ohio exceeded the national average during that same time period with 85 percent of adults ages 20 and over receiving a preventative health visit.
- 97% of Medicaid Care Coordination Plans interact with schools, 89% with volunteer organizations, such as local branches of the American Cancer Society, and 87% with faith-based organizations.

*Such as transportation, provider incentives, chronic disease management, wellness promotion and other care coordination services.

How an Ohio Medicaid Premium Dollar is spent

- 46¢ Hospital Care
- 19¢ Physician/Professional care
- 16¢ Prescription drugs
- 10¢ Dental, vision, and other medical services
- 9¢ Value-added managed care services*
Medicaid Managed Care in Ohio (cont’d)

- Ohio has expanded to nearly 100% mandatory
- “Platform” for Ohio’s Medicaid delivery system
- It’s changed/matured in last 5 years
- Topics:
  - Fundamentals, Tools, Features, Elements, Characteristics
  - Care Management
Almost 100% mandatory enrollment, \textbf{EXCEPT}:

- \textbf{EXCLUDED}: Adults and kids in institutions, on spend down, on a waiver, or dually eligible/MME. Also excluded: ABD kids on BCMH with CF, cancer, or hemophilia through 6/30/14 (enrollment becomes voluntary for them on 7/1/14).
  
  - ICF/IDD Waivers: DODD-IO, Level 1, Self, Transitions DD
  
  - NF LOC: PASSPORT, Choices, Assisted Living, Ohio Home Care, Transitions II Aging Carve-out waivers

- \textbf{VOLUNTARY}: <19 years old and receiving title IV-E foster care or adoption assistance, in foster care or other out of home placement, or on BCMH.
Medicaid Managed Care Program
Managed Care Regions
Effective July 1, 2013

Ohio Department of Job and Family Services
Medicaid Managed Care Tools

- Prior authorization requirements


<table>
<thead>
<tr>
<th>Category</th>
<th>Managed Care Plan</th>
<th>Notes: *ALL NON-PAR SERVICES REQUIRE PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy -Occupational, Physical &amp; Speech</td>
<td>Initial eval and first 12 visits no PA if par (excluding HH) No</td>
<td>ST: Yes / PT and OT: after 6 visits (excluding evaluation) After the first 12 visits No (Yes, if &gt; 30 visits)</td>
</tr>
<tr>
<td>Specialty Referrals</td>
<td>Yes (some) No OON only OON only OON only</td>
<td>OON=out of network</td>
</tr>
</tbody>
</table>


What is care management in Medicaid managed care?

- Managed care assumes coordination of all health care services
  - Carve out issue
- Telephonic care management-various team models
- Disease management programs
- Utilization management
- Call centers, nurse lines
- Occasional use of home health care services when face to face required
Changes to Ohio Care Management Requirements

- “Basic” care management requirements – program that coordinates and monitors care for enrollees with complex needs. Identify, assess, and develop plan of care.

- Telephonic care management (<15% of total).

- Since Oct. 2011, MCPs have greater care management requirements for top 1% of each MCP’s population deemed “high-risk.” Ratio of 1 to 25.
  - Includes quarterly face-to-face visits.

- Disease management programs.
Profile of LTSS 2012

- From 2008 to 2012 # LTSS programs from 8 to 16
- Inc. older adults, those with physical disabilities & IDD
- ½ mandatory- ½ voluntary

Corporate Status
- For Profit- 3 states = 44% total population
- Non Profit- 3 states = 32%
- Government- 3 states = 24%
- Mix Profit & Nonprofit - 5 states

Major national players
- UHC, Amerigroup, Centene, Molina

2012 total ~800,000 enrolled
Financial Arrangements & Risk

- 6 states comprehensive capitated rate
- 5 capitated fully for Medicaid & Medicare
- 12 offer self direction
- 11 offer MFP like services

Note: Categories are not mutually exclusive.
Reimbursement & Incentives

• Pay same rate NF/community, not higher in NF

• Partial capitation-risk corridor for NF care, i.e., capitation includes 180 days NF & remaining services ongoing

• Reward plans for Transition to community, and disincentivize NF
  – Mass. - When transition TO NF- after 90 days, 90% NF rate. When transition to community, pay 100% NF rate for 90 days.

• P4P re: carved out services

• CMMI Dual eligible models
New Programs Projected by Jan. 2014

Figure 12.1: States Planning to Implement New MLTSS Programs by January 2014

Note: We included States that have public plans for new MLTSS programs that include: a public planning document, request for information, request for proposals; proposal to CMS or waiver application to CMS. Submitting a letter of intent to CMS for the Medicare-Medicaid Financial Alignment Demonstration was not by itself sufficient to be included here.
Existing + New = 26 States

Figure 12.2: All States Projected to Have MLTSS Programs by January 2014 (Existing and New)
Medicare Advantage Plans
About Medicare Advantage Plans


• BBA authorized CMS to contract with public or private organizations to offer a variety of health plan options for beneficiaries, including:

  – Coordinated care plans (such as health maintenance organizations (HMOs), provider sponsored associations (PSOs), and preferred provider organizations (PPOs)).
  – Medicare Medical Savings Account (MSA) plans.
  – Private-fee-for-service (PFFS) plans.
  – Religious Fraternal Benefit (RFB) plans.

• The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added regional PPOs (RPPO) and special needs plans (SNPs).
Some Types of Medicare Advantage Plans

• **HMOs**
  – Limit the range of available providers to a defined network.
  – May require an individual to seek a referral from a PCP to see a specialist.

• **PPOs**
  – Requires an individual to pay more to use providers that are out of network.

• **SNPs**
  – Limited to people with specific diseases or characteristics.
  – Tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.
  – Generally requires the individual to use a network provider.
Some Types of Medicare Advantage Plans (cont’d)

• **SNPs (cont’d)**
  – All SNPs must provide Medicare prescription drug coverage.
  – In most cases, SNPs may require the individual to have a primary care doctor or a care coordinator.
  – A plan must limit membership to these groups:
    • People who live in certain institutions (like a nursing home) or who require nursing care at home, or
    • People who are eligible for both Medicare and Medicaid, or
    • People who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia).
    • Plans may further limit membership.
In addition to the Medicare services that all Medicare Advantage Plans offer, Medicare SNPs may also cover extra services tailored to the special groups they serve, like extra days in the hospital.

– A D-SNP is a SNP for individuals enrolled in both Medicare and Medicaid.
How do Medicare Advantage Plans work?

- Offered by private companies approved by Medicare.
- All types of Medicare Advantage Plans cover emergency care.
- MA Plans must cover all of the services that Original Medicare covers except hospice. Original Medicare covers hospice care even for individuals in a MA Plan.
- Prescription drug coverage is typically offered through a MA plan. In some types of plans that don't offer drug coverage, an individual can join a Medicare Prescription Drug Plan.
  - An individual cannot have prescription drug coverage through both a Medicare Advantage Plan and a Medicare Prescription Drug Plan.
- In addition to the Medicare Part B premium, individuals enrolled in a Part C plan pay a separate monthly premium.
Seniors and others who qualify for Medicare can receive their coverage through a Medicare Advantage Plan.

- Medicare Advantage plans provide extra services to members, such as dental, vision, smoking cessation, and health and wellness offerings.
- 14 of OAHP’s member plans offer Medicare Advantage Plans.
- 32% of Ohio’s Medicare beneficiaries, or 576,000 Ohioans, are enrolled in Medicare Advantage Plans. (Source: Ohio Department of Insurance)
- Ohioans enrolled in a Medicare Advantage Plan pay less than the national monthly average for Medicare Advantage plans.
- 90% of plans have no co-payment for preventive services and screenings.
- 84% member satisfaction reported. (HHS)
- Ohio’s health plans offer Special Needs Plans (SNPs) for those eligible for both Medicare and Medicaid and have specific chronic or disabling conditions like diabetes, congestive heart failure, mental illness or HIV/AIDS.

Ohio’s Integrated Care Delivery System
An Opportunity

• There are unique opportunities to improve the service delivery and payment systems for care provided to Medicare-Medicaid Enrollees (MMEs).

• Ohio Medicaid is focusing on making the two programs work together more effectively in order to improve care and lower costs.

• How? By creating an Integrated Care Delivery System (ICDS) to comprehensively manage the full continuum of benefits for MMEs – long term services and supports, behavioral-health services, and physical health services.

• ICDS Plans will allow enrollees to directly access in-network specialists without referrals.
About MMEs

• Approximately nine million Americans are enrolled in both Medicare and Medicaid (“Medicare-Medicaid enrollees” or “MMEs”).
  – 182,000 Ohioans.

• MMEs account for 21% of Medicare enrollees and 15% of Medicaid enrollees, and 36% and 39% of each program’s spending, respectively.
  – In Ohio, 9% of Medicaid enrollment & 30% of spending.

• Two-thirds of MMEs are low-income elderly, one-third are individuals younger than age 65 with a disability.
• Other important facts about MMEs:
  – MMEs’ health costs are nearly five times greater than those of all other people with Medicare.
  – Compared with all other Medicaid enrollees, MMEs’ health costs are nearly six times greater.
  – MMEs are three times more likely to have a disability, and overall these individuals have higher rates of diabetes, pulmonary disease, stroke, Alzheimer’s disease, and mental illness.
**MMEs – Service Utilization**

*Figure 11. Distribution of Fee-for-Service Spending: Full Benefit Enrollees: Ohio, 2007*

**Medicare**
- Outpatient Hospital: 11%
- Part D Drugs: 23%
- SNF: 11%
- Inpatient Hospital: 28%
- Physician: 9%
- DME: 2%
- Other: 9%
- Hospice: 4%

**Medicaid**
- Community-based LTSS: 30%
- Institutional LTSS: 61%
- Other: 9%
- Drugs: <1%

**Medicare FFS Spending:** $3.4B

**Medicaid FFS Spending:** $4.3B

Note: Institutional LTSS includes nursing facility, intermediate care facility for the mentally retarded, inpatient psychiatric facility for the under-21, and mental hospital for the aged. Community-based LTSS includes State Plan Services such as Home Health and Personal Care and HCBS waivers which allow states to provide a broader array of LTSS to persons living in the community than those covered in the State Plan.

The largest share of Full Benefit enrollees’ FFS Medicare spending went toward Inpatient Hospital care, whereas the largest share of FFS Medicaid spending went toward Institutional LTSS.

MMEs – Service Utilization

Utilization

Figure 8. Percentage of Fee-for-Service Beneficiaries Using Select Medicare Health and Post-Acute Services by Enrollment Group: Ohio, 2007

Full Benefit enrollees tended to use select Medicare services at higher rates than Medicare-only beneficiaries. Utilization was measured by the percentage of people using the service.

The majority of Full Benefit enrollees in Ohio used Medicaid-funded LTSS. Of those, 61% used institutional LTSS and the remainder used community-based LTSS.

MMEs – Chronic Conditions

Chronic Conditions

**Figure 6. Number of Chronic Conditions by Enrollment Group: Ohio, 2007**

- Full Benefit
- Medicare-only

Note: Findings related to chronic conditions were not age-adjusted. At the time the Profiles were developed, the data source did not capture the range of mental health or developmental conditions, which disproportionately affect the age 18 - 64 Medicare-Medicaid enrollee population.

*Full Benefit enrollees were 3 times more likely than Medicare-only beneficiaries to have had 5 or more chronic conditions.*

MMEs – Chronic Conditions (cont’d)

** Full benefit enrollees had a greater prevalence of chronic conditions than Medicare only
Depression Period Prevalence, 2011

SOURCE: Chronic Condition Data Warehouse (CCW). Medicare Beneficiary Summary Files.

Info includes all Medicare, not just MMEs
What’s so important about MMEs?

• Medicaid and Medicare are designed and managed with almost no connection to each other.

• Long-term services and supports (LTSS), behavioral health services and physical health services provided to MMEs are poorly coordinated.

• Result is a diminished quality of care, reflected in high costs to the Medicaid system and to taxpayers.
Medicare and Medicaid

- Medicare is primary payer.
- For services that both Medicare and Medicaid cover (e.g., doctors’ visits, hospital care, home care & SNF), Medicare pays first and Medicaid pays second, by covering remaining costs such as Medicare coinsurance or copayment, if any.
- Medicaid will also pay for medical services not covered at all by Medicare, as long as they are covered by Medicaid.
- If an individual has Medicare and full Medicaid, Medicare covers Part D prescription drugs. Medicaid may still cover some drugs that Medicare doesn’t cover. If an individual has Medicare and qualifies for a Medicaid program, he or she then automatically qualifies for Extra Help, the federal program that helps with the cost of Medicare prescription drug coverage.
What Medicare Covers

• **Medicare Part A**
  – Inpatient hospital
  – Skilled nursing facility
  – Hospice
  – Home health
  – Inpatient mental health

• **Medicare Part B**
  – Physician
  – Outpatient hospital
  – Ambulance
  – Home health
  – Durable medical equipment
  – Outpatient mental health
  – Laboratory
  – Outpatient physical, occupational, and speech-language therapy
  – Some preventive services

• **Medicare Part D**
  – Prescription drugs
What Ohio Medicaid Covers

- Ambulance/ambulette
- Ambulatory surgery centers
- Certified family nurse practitioner
- Certified pediatric nurse practitioner
- Chiropractic
- Community alcohol & drug addiction treatment
- Community mental health
- Dental
- Durable medical equipment & supplies
- Family planning services & supplies
- Healthchek (EPSDT) (screening & treatment services to children 21 and younger)
- Home- and community-based services waivers
- Home health
- Hospice care
- Independent psychological
- Inpatient hospital
- Intermediate care facility for individuals with developmental disabilities (ICF-DD)
- Lab & x-ray
- Medical & surgical dental
- Medical & surgical vision
- Medicare premium assistance
- Non-emergency transportation (NET) to Medicaid services
- Nursing facility
- Occupational therapy
- Outpatient services, including those provided by Rural Health Clinics & Federally Qualified Health Centers
- Physical therapy
- Physician
- Podiatry
- Pregnancy related services
- Prescription drugs
- Private duty nursing
- Speech therapy
- Vision care, including eyeglasses

Note: Boldfaced services are those that may also be covered by Medicare.
• August 2012 – Ohio selected five health plans (Aetna, Buckeye, CareSource, Molina and United) to manage and coordinate the care of MMEs in the ICDS.

• Will be launched in March 2014 as a five year project in 7 regions covering 29 Ohio counties and approximately 114,000 individuals.

• Will allow Ohio to identify & incentivize innovative techniques for improving care to a highly acute population.

• Vehicle is 1915(b)/(c) waivers.

• Third state to get federal approval.

• Three-way contract – Medicare, Medicaid & ICDS plans.

• Medicaid rates released October 2013. As of October 9, still waiting for Medicare rates. **Rates include behavioral health.**
What is a 1915(b)/(c) Waiver?

• Used to implement a mandatory managed care program that includes home- and community-based waiver services in a managed care arrangement.

• The 1915(b) authority is used to mandate enrollment in managed care and limit freedom of choice and/or selectively contract with providers.

• The 1915(c) authority is used to target eligibility to Medicaid consumers with a certain level of care and provide home- and community-based services.

• The state must submit a separate application for each waiver as described above.
## ICDS Basics

<table>
<thead>
<tr>
<th>Demonstration Region &amp; Population</th>
<th>Managed Care Plans Available</th>
</tr>
</thead>
</table>
| **Northwest: 9,884**  
Fulton, Lucas, Ottawa, Wood | - Aetna  
- Buckeye |
| **Southwest: 19,456**  
Butler, Clermont, Clinton, Hamilton, Warren | - Aetna  
- Molina |
| **West Central: 12,381**  
Clark, Greene, Montgomery | - Buckeye  
- Molina |
| **Central: 16,029**  
Delaware, Franklin, Madison, Pickaway, Union | - Aetna  
- Molina |
| **East Central: 16,225**  
Portage, Stark, Summit, Wayne | - CareSource  
- United |
| **Northeast Central: 9,284**  
Columbiana, Mahoning, Trumbull | - CareSource  
- United |
| **Northeast: 31,712**  
Cuyahoga, Geauga, Lake, Lorain, Medina | - Buckeye  
- CareSource  
- United |
ICDS Plan

- Some ICDS plans are Medicare Advantage plans and some are Dual Eligible Special Needs Plans (D-SNPs)
Who is eligible to participate in the ICDS?

- Individuals fully enrolled in Medicaid and Medicare.
- Hospital or nursing facility LOC; *not* intermediate care facility LOC.
- There will be four groups that will meet eligibility criteria and will need their own transition processes.
- Approximately 37,000 unduplicated individuals will participate in the ICDS in Year 1, many of whom will transfer from one of Ohio’s five NF-based waivers.
- Will grow to 41,700 in Year 3 of the demonstration.
Who is *not* included?

- Individuals with intellectual disabilities and other developmental disabilities who are otherwise served through a 1915(c) HCBS waiver or an ICF.
- Individuals enrolled in PACE.
- Individuals enrolled in both Medicare and Medicaid who have other third party creditable health care coverage.
- Individuals under the age of 18.
- Individuals who are Medicare and Medicaid eligible and are on a delayed Medicaid spend down.
- Individuals participating in the CMS Independence at Home (IAH) demonstration.
Groups to Transition to ICDS

Four groups to transition to ICDS:

1. Individuals currently enrolled in PASSPORT, Choices, Assisted Living, Ohio Home Care, Transitions II Aging Carve-out waivers.

2. “Community well” individuals who experience a significant change that presents a new need for LTSS.

3. Current NF residents transitioning into the community who have a need for LTSS.

4. Individuals newly eligible for either or both Medicare and Medicaid, are otherwise eligible for the ICDS, and are enrolled on a HCBS waiver during their FFS Medicaid period before they are enrolled on an ICDS plan.
### What happens to someone currently on a NF LOC waiver?

<table>
<thead>
<tr>
<th>NF LOC Waiver</th>
<th>If individual eligible for ICDS?</th>
<th>If individual not eligible for ICDS?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASSPORT</td>
<td>Disenrolled from PASSPORT waiver and enrolled in ICDS waiver</td>
<td>Stay in PASSPORT waiver</td>
</tr>
<tr>
<td>Choices</td>
<td>Disenrolled from Choices waiver and enrolled in ICDS waiver</td>
<td>Stay in Choices waiver</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>Disenrolled from Assisted Living waiver and enrolled in ICDS waiver</td>
<td>Stay in Assisted Living waiver</td>
</tr>
<tr>
<td>Ohio Home Care</td>
<td>Disenrolled from Ohio Home Care waiver and enrolled in ICDS waiver</td>
<td>Stay in Ohio Home Care waiver</td>
</tr>
<tr>
<td>Transitions II Aging Carve Out</td>
<td>Disenrolled from Transitions II Aging Care Out waiver and enrolled in ICDS waiver</td>
<td>Stay in Transitions II Aging Carve Out waiver</td>
</tr>
</tbody>
</table>
Transition to ICDS

• Individuals in groups 2 and 3 (new need for LTSS or NF resident transitioning to community) will move directly onto the ICDS demonstration without a “transition period.”

• For individuals in groups 1 & 4 (coming off NF LOC waiver or newly eligible for Medicaid and/or Medicare), ICDS plans will be required to contract with each individual’s established providers for the periods of time approved under the individual’s currently approved waiver service plan.
  – Waiver personal care assistance, nursing, out-of-home respite, enhanced community living, adult day services, social work/counseling and independent living skills providers will be maintained for 365 days unless a change is required.
  – All other waiver service levels will be maintained for 365 days, and providers will be maintained for 90 days.
Enrollment

- MMEs who do not choose an ICDS plan will be passively enrolled.
- Enrollees will have the choice of two or more ICDS plans.
- MMEs may opt out of ICDS for Medicare services, but will be mandatorily enrolled in Medicaid benefits after the 60 day choice period and cannot opt out on the Medicaid side.
- ODA and the PASSPORT Administrative Agencies will perform the LOC determinations/redeterminations for individuals enrolled in the ICDS Waiver.
Why opt out on the Medicare side?

- Medicaid will be mandatory. Medicare voluntary.
- Doc or other Medicare service not part of the MCP network.
Auto-Assignment

- The assignment algorithm for passive enrollment will use historical Medicaid claims to identify the enrollee’s historical providers in order to prioritize continuity of providers and/or services.

- The auto-assignment process will assign the enrollee to the ICDS Plan that has the provider (or specialist) most often used by the individual for which the Medicaid system has a claim.

- If there is no existing relationship with a provider or there is more than one ICDS Plan with the same provider with the greatest number of visits historically on the panel, the individual may be assigned to an ICDS Plan based on a round robin methodology or the ICDS Plan’s enrollment thresholds.
ICDS Goals

• Reduction in costs should enable more MMEs to receive the services they need in their own homes and other community-based settings, rather than in more costly institutional setting.

• Improved outcomes for MMEs.

• Assure continuity of care by offering HCBS that are consistent with the services available in Ohio’s five NF LOC waivers.
Waiver Services

• For individuals in groups 1 and 4 (coming off NF LOC waiver or newly eligible for Medicaid and/or Medicare), each individual’s service plan will be updated to reflect the service nomenclature in the ICDS waiver utilizing the cross-walk included in the waiver application.

• Individuals may change waiver service providers at any time. However, any change (initiated by either the individual or the ICDS plan) may occur only after an in-home assessment and the development of a plan for the transition to a new provider. In cases where the health and welfare of the individual is judged to be in danger, expedited service authorization time frames will apply per 42 CFR 438.206(d).
Waiver Services (cont’d)

• The ICDS Waiver will offer an array of services consistent with Ohio’s five NF LOC waivers in order to assure continuity of care for individuals transferring from one of those waivers to the ICDS Waiver.

• The full range of services will be available to the individual based upon identified need, regardless of the waiver from which he or she transfers.
ICDS Waiver Services

- Homemaker
- Personal care
- Adult day health
- Emergency response
- Home delivered meals
- Alternative meals
- Home modifications, maintenance and repair
- Home medical equipment and supplemental adaptive and assistive devices
- Waiver transportation
- Out-of-home respite
- Waiver nursing
- Home care attendant
- Chore
- Community transition
- Enhanced community living
- Independent living assistance
- Nutritional consultation
- Social work counseling
- Choices home care attendant
- Pest control
- Assisted living services

See separate services crosswalk handout
Rates for ICDS Plans

- Rates for ICDS plans will be per member per month (PMPM).

- The PMPM rates cover the coordination of all physical and behavioral health services, as well as LTSS, reimbursed by Medicaid and/or Medicare.

- There will be different rates for individuals for whom the plan is coordinating both Medicaid and Medicare services v. just Medicaid services (i.e., if an individual opts out on the Medicare side).
Quality and Data Reporting

- ICDS plans are subject to external quality review activities.
- They also must report data to the state detailing program administrative activities including, but not limited to, individual requests for services and access to care, the number of grievances and appeals, waiver enrollment and disenrollment figures, as well as certain waiver service coordination requirements such as compliance with contact schedules.
- Additionally, the state will contract with a provider oversight contractor to perform a variety of tasks, including incident management and investigation, operating an alerts process, and performing structural reviews of providers to monitor provider compliance with applicable conditions of participation.
- When the AAAs perform LOC evaluations for individuals in the ICDS, they must report data to the state.
- ICDS plans are subject to performance measurement.
Care Management/Service Coordination

• The individual will be assigned both an **ICDS plan care manager** and a **waiver service coordinator**.

  – Why both? The state believes that the relationship between the individual and his or her waiver service coordinator has a significant impact on outcomes.

• The **care manager** will lead and coordinate the individual's trans-disciplinary team and ensure overall coordination between acute care and waiver services.

• The **waiver service coordinator** is the waiver service expert who will ensure that all functions under the waiver occur and that health and welfare checks are made as needed.

• Depending on the structure of the ICDS plan’s care management program, **the roles of the waiver service coordinator and the care manager may be filled by the same person**.
Responsibilities of ICDS Plan Care Manager

- Serves as the accountable point of contact for the individual.
- Identifies and negotiates roles & responsibilities for all team members.
- Arranges for or conducts the comprehensive assessment.
- Develops, implements, and monitors the comprehensive care plan.
- Directs all care management activities (e.g., delegates tasks to team members, completes the care gap analysis, and structures the in-person contacts to ensure alignment with the care plan goals/interventions).
- ODM will not dictate minimum requirements for care managers, but they must have the skills necessary to coordinate the full array of services required by the individual.
Responsibilities of Waiver Service Coordinator

- Ongoing assessment of LTSS for individuals currently receiving waiver services.
- Initial LTSS assessment for individuals who present a need (i.e., community well individuals).
- Waiver service plan development, review, and updates.
- Crisis intervention, event-based visits, provider monitoring, and assisting individuals with self-directed care.
- Directly employed by the ICDS plan or through a contracted delegated arrangement.
- Accountable to the ICDS plan care manager, who is ultimately responsible for ensuring the appropriate development of the waiver service plan and its integration to the comprehensive plan of care.
Who will do waiver service coordination?

• The ICDS plans will be required to contract with AAAs to perform waiver service coordination for, at a minimum, those individuals age 60 and older; and/or

• ICDS plans may also choose to subcontract waiver service coordination to additional entities that have experience working with people with disabilities and/or chronic conditions including, but not limited to, centers for independent living and disability-oriented case management agencies; and/or

• The ICDS plans may also provide waiver service coordination themselves.

• Individuals will be given the right to choose from available entities that will provide waiver service coordination. Individuals age 60 and older who do not choose a waiver service coordinator will be assigned one from the AAA.
Functions of the ICDS Plans

• Arrange for care and services by specialists, hospitals, and providers of LTSS and other non-Medicaid community-based services and supports.

• Allocate increased resources to primary and preventive services in order to reduce utilization of more costly Medicare and Medicaid benefits, including institutional services.

• Cover all administrative processes, including consumer engagement, which includes outreach and education functions, grievances, and appeals.
Functions of the ICDS Plans (cont’d)

- Use a person-centered care coordination model that promotes an individual’s ability to live independently through a process that emphasizes the role of the individual in the development of his or her care plan.

- Use a payment structure that blends Medicare and Medicaid funding and mitigates the conflicting incentives that exist between Medicare and Medicaid.

- Ensure that members of the individual’s trans-disciplinary team, including staff directly employed by the plan or a delegated entity that is completing care management activities, are appropriate for responding to and managing the individual’s needs and follow the state’s licensure/credentialing requirements.
Compare: NY’s MME Plan

• Working on a multi-phase plan to move many individuals requiring LTSS into managed care

• Phase 1 (managed long-term care plans): LTSS (not DD) go into managed care

• Phase 2 (fully integrated dual advantage plans): DD services + LTSS + BH services + acute care services go into managed care

• Phase 3 and beyond: evolution of MLTCPs and FIDAs into another framework?
Interaction With Other Ohio Initiatives

- Other 1915(c) HCBS waivers
- “Regular” managed care
- Health homes
- Other
ICDS and 1915(c) HCBS Waivers

- Individuals who are currently on one of the 5 NF LOC HCBS waivers and who become eligible for the ICDS will be disenrolled from their current waiver and enrolled in the ICDS waiver.

- Individuals who are currently on one of the 5 NF LOC HCBS waivers and who do not become eligible for the ICDS (e.g., non-MMEs or non-FULL MMEs) will remain on their current waivers.

- Individuals who are currently on one of the DD LOC HCBS waivers will not be eligible for the ICDS and will remain on their current waivers.
ICDS and “Regular” Managed Care

• Individuals who are eligible for the ICDS are *not* also eligible for “regular” managed care.

• Some other elderly individuals who are *not* eligible for the ICDS *may* be enrolled in “regular” managed care:
  – Non-MMEs
  – Not in an institution (e.g., NF, ICF)
  – Not on spend down
  – Not on a waiver
ICDS and Health Homes

- Ohio is implementing a health home initiative for individuals with serious and persistent mental illness.

- Health homes aim to integrate physical and behavioral health care by offering medical, behavioral, and social services that are coordinated by an individualized treatment team. In Ohio, currently, health homes are community mental health centers.

- MMEs with serious and persistent mental illness are eligible to participate in health homes.

- Although the state has not produced any guidance on how care will be coordinated for MMEs enrolled in both an ICDS plan and a health home, it is safe to assume that an individual can be enrolled in both.
Questions or Discussion
About Vorys Health Care Advisors

Vorys Health Care Advisors, LLC helps health care providers, business decision makers and professional associations to achieve their objectives in a constantly changing governmental and business health care environment and to assist them in making well informed, strategic and tactical decisions tailored to their individual goals, needs and aspirations.

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