

# Medicaid Managed Care for Individuals Enrolled on a DODD Waiver

Office of Managed Care  
Ohio Department of Medicaid  
Summer 2017





# Introduction

- » Medicaid is Ohio's largest health payer delivering services for nearly 3 million individuals insured by Medicaid
- » Over 2.5 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 were recently added.

Population/Service	Managed Care Transition Date
Adult Extension members with HCBS Waiver	August 2016
Medicaid covered Individuals enrolled in the BCMH program	January 2017
Children in Custody/Adoption	January 2017
BCCP	January 2017
Individuals enrolled on a DD waiver	Voluntary January 2017



# Acute Health Care Coverage Options

Traditional Fee for Service Medicaid

- or -

Medicaid Managed Care

As of January 1, 2017, individuals participating in waivers administered by DODD may choose to have Medicaid Managed Care coverage for their acute health care (state plan) services.



# Medicaid Services

## » Acute health care (state plan) services:

- Doctor visits
- Prescriptions
- Hospital services (Inpatient/Outpatient)
- Labs and X-ray services
- Vision / Dental
- Durable Medical Equipment (DME)
- Home Health

## » Habilitative (waiver) services:

- Homemaker/personal care
- Adult day services
- Supportive Employment
- Respite services



# Habilitative Waiver Services Coverage

- » DD waiver services are “carved out” of managed care, which means the services are paid for through fee for service.
  
- » Waiver services, billing, and management for those services remain the same for individuals if they choose to enroll in managed care:
  - Providers
  - Service Packages
  - Service Delivery
  - Authorization
  - Provider Reimbursement



# Benefits of Managed Care

- » Managed Care has been proven to promote the health and well-being of participants through a variety of approaches.
  - Focus on preventative care and chronic condition control
  
- » MCPs are Required to cover all medically necessary, Medicaid covered services.
  - Targeted improvement efforts to align with state priorities



# Benefits of Managed Care

Member benefits include:

- » Expanded access to care and provider networks
  - Assistance finding providers and setting up appointments
  - Transportation to and from medical appointments
- » Dedicated points of contact
  - Toll-free member services call center
  - Toll-free nurse advice line available 24/7
- » Participation incentives
- » Health and wellness programs
- » Care management
  - Intensity level of care management is determined by the particular needs of each participant



# Transition of Care

- » Data files are sent to MCPs containing prior services, providers, prescriptions, and prior authorization information when individual enrolls.
- » MCP requirements
  - Maintain current level of services(eg. physician, durable medical, and pharmacy – 90 days)
  - Levels may change upon review for medical necessity after transition period ends
- » Prescriptions
  - MCPs must cover prescription refills during the first three months of membership for prescriptions covered by Ohio Medicaid during the prior fee-for-service enrollment period.
  - The prescribing provider will need to submit a request for prior authorization as needed after initial transition period.
  - Prior authorization for outpatient medications should be determined within 24 hours

# MCPs and SSAs must work together to assure individual's needs are being met.





# Responsibilities of MCPs and SSAs

## Managed Care Plan (MCP):

- Initial identification of MCP enrollment to DODD County Boards.
- Obtain/maintain contact information for SSA.
- Provide information promptly to SSA on state plan services for inclusion in the Individualized Service Plan (ISP), including EPSDT services for children.
- Responsible for provision and coordination of state plan services.
- Communicate prior authorization decisions on all state plan services and equipment to the SSA.
- Report incidents to DODD Abuse/Neglect Hotline.

## Support Service Administrator (SSA):

- Contact MCP to identify point of contact for assistance, questions, information about a specific individual.
- Communicate best method to share ISP with the Managed Care Plan.
- Responsible for provision and coordination of waiver services.
- Contact MCP if assistance is needed for individual to access state plan services:
  - MCPs can require members to use contracted providers
  - MCPs can have different prior authorization requirements



# MCP and SSA Collaboration and Coordination

- » Discuss role delineation between the MCP and SSA with goal of complementing each other's expertise, capabilities, and experience and focus on person-centeredness.
- » Open lines of communication regarding individual's needs, provision of services, change in behavior or health status, hospitalizations, incidents, etc.
- » List each other as team members in systems, ISPs, care plans, etc., to assure overall awareness and coordination.
- » Conduct warm hand-offs, as needed, if contacted by the member and require assistance from the SSA or MCP partner.



# How to Enroll in Managed Care

» Enrollment can be accomplished by contacting the Medicaid Consumer Hotline at 800-324-8680 or online at <https://www.ohiomh.com/>.

- Helping the consumer choose the most appropriate plan
- Answering questions about the MCPs
- Requests to change MCPs
- Requests to disenroll

» The individual on a waiver or his/her guardian or authorized representative can select a managed care plan or choose to opt out of managed care if fee for service coverage is preferred.



# Frequently Asked Questions (FAQ)

» If I switch plans, does my information transfer to the new plan?

- Up to two years of historical data about the health services received will be sent to the new MCP

» What happens if I move to another county?

- All plans are statewide, plan will be able to help identify new providers

» What happens if managed care enrolled individual goes in to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)?

- For a temporary stay or waiver residential respite services, individual will remain enrolled in managed care



## FAQ cont.

- » What happens if I'm enrolled in Medicaid managed care prior to enrollment in HCBS waiver administered through DODD?
  - Individual remains enrolled in managed care
- » Where is information about a plan's preferred drug list?
  - Each MCP website provides access to their list
- » Can SSA still bill Targeted Case Management (TCM)?
  - Yes. There is no change to the TCM billing process



# FAQ cont.

## » How are prior authorization requests for medical equipment submitted?

- Requests for medical equipment should be submitted through the MCP prior authorization process, typically these are submitted by the durable medical equipment provider.

## » How is medical necessity determined?

- MCPs follow Medicaid fee-for-service rules and clinical criteria when making a determination of medical necessity.
- MCPs are not able to use criteria that is more stringent than Medicaid fee-for-service rules.

## » What is MyCare?

- MyCare is a managed care program for dual eligible individuals that coordinates Medicare and Medicaid services.
- Individual would forfeit DD waiver and services to enroll in MyCare.

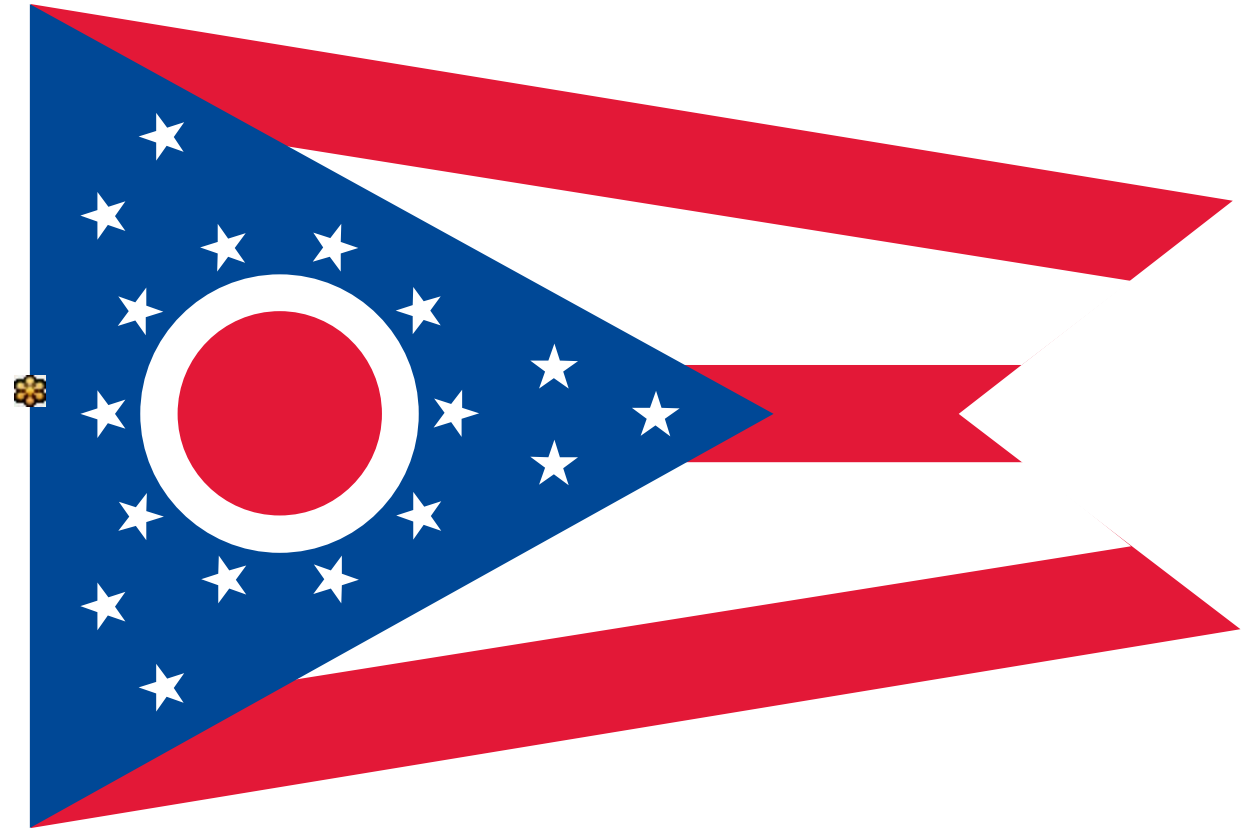


# Questions



Thank you very much!!

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)

# 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

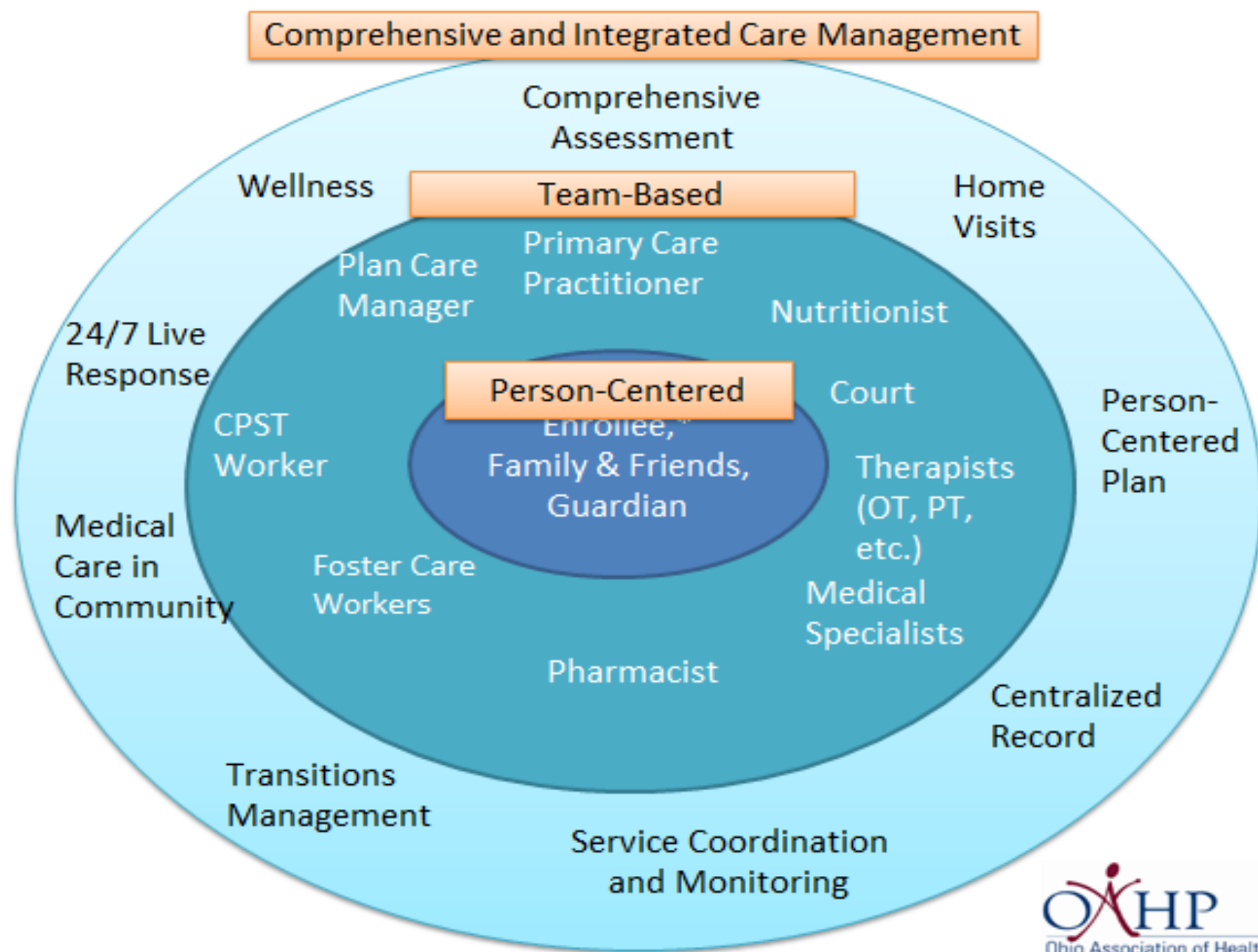
# Care Management Overview

# 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

# Appeals

- If a member does not agree with a decision they can request an appeal with the MCP. The member's 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 60 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

# How To Contact Us

Primary Contacts:

Tiffany Deknight MSW, LISW, CCM  
Supervisor Care Management, Behavioral health  
(513) 469-4523 office  
(513) 630-7189 Cell  
[Tiffany.A.Deknight@centene.com](mailto:Tiffany.A.Deknight@centene.com)

Laura Paynter, Director of Care Management, Behavioral Health  
[lpaynter@centene.com](mailto:lpaynter@centene.com)  
Office: 866-246-4356 ext. 24446  
Cell: 216-319-0481

Stephan Young, Clinical Director  
[styoung@centene.com](mailto:styoung@centene.com)  
Office: 866-246-4356 ext. 24510  
Cell: 513-377-2668

Member Services: 1-866-246-4358  
Nurse Advice Line: 1-866-246-4358, Option 7  
Website: [www.buckeyehealthplan.com](http://www.buckeyehealthplan.com)





Primary Contacts:

Sherry Spehr, Mgr Clinical Operations

[Sherry.Spehr@caresource.com](mailto:Sherry.Spehr@caresource.com)

937-531-2780 (work)

937-266-4807 (mobile)

Teri Krapf (back-up), Mgr Logistics Ctr

[Theresa.Krapf@caresource.com](mailto:Theresa.Krapf@caresource.com)

937-531-2168 (work)

937-546-0953 (mobile)

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

Nurse Advice Line: 1-866-206-0554 (TTY 1-800-750-0750 or 711)

Website: [www.caresource.com](http://www.caresource.com)

Primary Contact:

Deidre Palmer, LPC, LSW, Manager for Healthcare Services  
800-357-0146, ext. 216341

[Deidre.Palmer@MolinaHealthcare.com](mailto:Deidre.Palmer@MolinaHealthcare.com)



Secondary Contact:

Christine Day, RN, CCM, Manager for Healthcare Services  
800-357-0146, ext. 216344

[Christine.Day@Molinahealthcare.com](mailto:Christine.Day@Molinahealthcare.com)

Member Services: 1-800-642-4168 (TTY 1-800-750-0750)

Nurse Advice Line: 1-888-275-8750 (English), 1-866-148-3537 (Spanish), (TTY 1-866-735-2929)

Website: [www.molinahealthcare.com](http://www.molinahealthcare.com)



Primary Contact:

Natalie Hicks MBA, LSW - Senior Regional Outreach Coordinator

419-887-2360

Cell: 614-537-4751

Fax: 419-765-4321

[natalie.hicks@promedica.org](mailto:natalie.hicks@promedica.org)



Secondary Contact:

Dr. Hy Kisin PH.D.

419-887-2251

Cell: 419-297-5677

FAX: 419-887-2028

[Hy.kisin@promedica.org](mailto:Hy.kisin@promedica.org)

Member Services: 1-800-462-3589 (TTY 1-888-740-5670)

Nurse Advice Line: 1-800-234-8773 (TTY 1-800-750-0750)

Website: [www.paramountadvantage.org](http://www.paramountadvantage.org)



Primary Contact:

Jodi Blacksher

[Jodi.blacksher@uhc.com](mailto:Jodi.blacksher@uhc.com) or [onmywayohioquestions@uhc.com](mailto:onmywayohioquestions@uhc.com)  
614-397-2947

Member Services: 1-800-895-2017

Nurse Advice Line: 1-800-542-8630

Website: [www.myuhc.com](http://www.myuhc.com) or [www.uhccommunityplan.com](http://www.uhccommunityplan.com)

