Managed Care – System Partnerships
Topic Areas...

- Value Based Contracting
- Comprehensive Primary Care
- Episodes of Care
- Specialty Programs
- How to Contact Us
What is Value Based Contracting?

“Value” is generally understood to be defined as the result of quality divided by cost, or the health outcomes achieved per dollar spent.

Value-based contracting involves payment or reimbursement based on indicators of value, such as patient health outcomes, efficiency, and quality.

This is distinct from volume or fee-for-service based contracting, which involves payment for every unit of service delivered, often without terms related to outcomes, quality, or cost performance.

Source: Kaufman Hall Associates
Why is it important?

• CMS oversees both Medicare and Medicaid, and we are starting to see State Medicaid programs driving similar goals.

• Medicare VBR payment requirements:
  – 20% of FFS payments in 2015
  – 30% of FFS payments in 2016
  – 50% of FFS payments in 2018
  – Estimate 80% of FFS payments by 2020

• OH Medicaid contracts must be 50% VBR by year 2020
Types of Payment Models

Payment models (aka APMs) currently being used are:

• Pay-for-performance (P4P)
• Bundled/episode based payments (DRG/Case Rates)
• Shared savings-shared risk (upside or downside)
• Full Risk/capitation (PMPM model)
• In Ohio Medicaid we currently see:
  – PCMH model of Care Coordination
  – Episodes of Care (upside/downside risk)
Ohio’s State Innovation Model (SIM) focuses on (1) increasing access to comprehensive primary care and (2) implementing episode-based payments.
# Ohio’s State Innovation Model (SIM) progress to date

<table>
<thead>
<tr>
<th>Comprehensive Primary Care</th>
<th>Episode-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care model and payment model design in place for model to reach 80 percent of Ohio’s population</td>
<td>• 13 episodes designed across seven clinical advisory groups (CAGs)</td>
</tr>
<tr>
<td>• <strong>Statewide provider survey</strong> gauged readiness</td>
<td>• 30 <strong>additional episodes</strong> under development to launch in 2017</td>
</tr>
<tr>
<td>• <strong>Infrastructure plan</strong> in place for attribution, enrollment, scoring, reporting, and payment</td>
<td>• <strong>Nine payers</strong> released performance reports on first wave of 6 episodes</td>
</tr>
<tr>
<td>• <strong>Ohio CPC performance report</strong> designed with provider/payer input</td>
<td>• State set <strong>thresholds for performance</strong> payments across Medicaid FFS and MCPs on first wave of episodes</td>
</tr>
<tr>
<td>• All payers applied for Ohio to be a statewide Medicare CPC+ region</td>
<td>• State released <strong>performance reports</strong> aggregated across Medicaid FFS and MCPs on second wave of 7 episodes</td>
</tr>
<tr>
<td></td>
<td>• <strong>Executive Order</strong> and rule require Medicaid provider participation</td>
</tr>
</tbody>
</table>
What should a Provider consider?

• Attribute Members – small patient population size can skew data.

• Normalize the data – review member risk scores, product mix, etc., and compare to peers.

• Define the Goal – what problem are you trying to solve?

• What’s in it for Me? – how does the provider potentially benefit?

• Perform a Risk Assessment – what level of “risk” can the provider tolerate?’

• What types of Quality/Performance measures could we include that would drive towards the defined goal?
VBR Model Characteristics

- Cost
- Quality
- Risk
- Volume/Membership
- Other context/color as needed

...let’s see this model in action ...
# A sample Cohort Snapshot

<table>
<thead>
<tr>
<th>COST</th>
<th>QUALITY</th>
<th>RISK</th>
<th>MEMBERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total BH Claims Cost</td>
<td>Average BH PMPM</td>
<td>30-Day Readmit Rate</td>
<td>7-Day SS3 Ra</td>
</tr>
<tr>
<td>$4,475,715.63</td>
<td>$5,633.31</td>
<td>18.82%</td>
<td>77.87%</td>
</tr>
<tr>
<td>$4,399,777.04</td>
<td>$6,777.67</td>
<td>15.18%</td>
<td>71.96%</td>
</tr>
<tr>
<td>$4,321,460.30</td>
<td>$6,688.46</td>
<td>23.10%</td>
<td>72.59%</td>
</tr>
<tr>
<td>$3,336,732.09</td>
<td>$5,878.30</td>
<td>20.23%</td>
<td>60.89%</td>
</tr>
<tr>
<td>$1,502,358.86</td>
<td>$4,333.64</td>
<td>11.25%</td>
<td>78.43%</td>
</tr>
<tr>
<td>$2,342,591.63</td>
<td>$4,213.00</td>
<td>20.39%</td>
<td>45.05%</td>
</tr>
<tr>
<td>$2,827,542.53</td>
<td>$6,292.91</td>
<td>13.84%</td>
<td>62.00%</td>
</tr>
<tr>
<td>$1,231,038.29</td>
<td>$6,583.48</td>
<td>12.50%</td>
<td>100.00%</td>
</tr>
<tr>
<td>$1,337,410.85</td>
<td>$3,500.08</td>
<td>15.18%</td>
<td>86.71%</td>
</tr>
<tr>
<td>$1,635,202.10</td>
<td>$4,422.15</td>
<td>17.33%</td>
<td>71.74%</td>
</tr>
<tr>
<td>$1,524,686.27</td>
<td>$4,095.56</td>
<td>10.94%</td>
<td>62.35%</td>
</tr>
<tr>
<td>$1,104,866.19</td>
<td>$3,465.76</td>
<td>6.25%</td>
<td>71.43%</td>
</tr>
<tr>
<td>$4,908,743.38</td>
<td>$505.72</td>
<td>12.50%</td>
<td>73.55%</td>
</tr>
<tr>
<td>$1,236,320.16</td>
<td>$335.20</td>
<td>17.54%</td>
<td>69.00%</td>
</tr>
<tr>
<td>$1,303,718.10</td>
<td>$443.22</td>
<td>23.61%</td>
<td>85.38%</td>
</tr>
<tr>
<td>$1,675,368.09</td>
<td>$535.59</td>
<td>15.91%</td>
<td>73.33%</td>
</tr>
<tr>
<td>$1,884,316.10</td>
<td>$453.50</td>
<td>5.88%</td>
<td>84.52%</td>
</tr>
<tr>
<td>$740,170.94</td>
<td>$357.73</td>
<td>0.00%</td>
<td>75.00%</td>
</tr>
<tr>
<td>$544,475.72</td>
<td>$145.57</td>
<td>13.23%</td>
<td>75.32%</td>
</tr>
<tr>
<td>$340,207.36</td>
<td>$743.93</td>
<td>5.86%</td>
<td>80.00%</td>
</tr>
<tr>
<td>$51,128.65</td>
<td>$459.06</td>
<td>34.73%</td>
<td>100.00%</td>
</tr>
<tr>
<td>$148,832.76</td>
<td>$468.06</td>
<td>20.00%</td>
<td>80.00%</td>
</tr>
<tr>
<td>$361,665.63</td>
<td>$436.94</td>
<td>17.55%</td>
<td>60.00%</td>
</tr>
<tr>
<td>$154,563.92</td>
<td>$139.33</td>
<td>25.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>$191,417.47</td>
<td>$439.99</td>
<td>14.23%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

**Total Cost:** $44,695,368.03  
**Total Quality:** $493.96  
**Total Risk:** 16,564  
**Total Membership:** 100.00%
Comprehensive Primary Care

• A patient-centered medical home program, which is a team-based care delivery model led by a primary care practice that comprehensively manages a patient’s health needs.

• CPC practices are eligible for additional payments beyond billed services:
  – *PMPM payment* to support care coordination activities
  – *Shared Savings payment* to reward practices for achieving total cost of care savings
Ohio’s Health

- Healthcare Spend: 18th
- Population health: 40th
- Life Expectancy: below national average
- Diabetes, Obesity, Smoking: higher than national average
- Rate of Infant Mortality: higher than national average
Ohio’s vision for CPC is to promote high-quality, individualized, continuous and comprehensive care

- **Patient Experience:**
  Offer consistent, individualized experiences to each member depending on their needs

- **Patient Engagement:**
  Have a strategy in place that effectively raises patients’ health literacy, activation, and ability to self-manage.

- **Potential Community Connectivity Activities:**
  Actively connect members to a broad set of social services and community-based prevention programs (e.g., nutrition and health coaching, parenting education, transportation)

- **Behavioral Health Collaboration:**
  Integrate behavioral health specialists into a patients’ full care

- **Provider Interaction:**
  Oversees successful transitions in care and select referring specialists based on evidence-based likelihood of best outcomes for patient

- **Transparency:**
  Consistently review performance data across a practice, including with patients, to monitor and reinforce improvements in quality and experience

- **Patient Outreach:**
  Proactive, targeting patients with focus on all patients including healthy individuals, those with chronic conditions, and those with no existing PCP relationship

- **Access:**
  Offer a menu of options to engage with patients (e.g., extended hours to tele-access to home visits)

- **Assessment, Diagnosis, Care Plan:**
  Identify and document full set of needs for patients that incorporates community-based partners and reflects socioeconomic and ethnic differences into treatment plans

- **Care Management:**
  Patient identifies preferred care manager, who leads relationship with patients and coordinates with other managers and providers of specific patient segments

- **Provider Operating Model:**
  Practice has flexibility to adapt resourcing and delivery model (e.g., extenders, practicing at top of license) to meet the needs of specific patient segments
Joining Medicaid’s CPC program gives practices access to data and reports that provide actionable, timely information needed to make better decisions about outreach, care and referrals.
## CPC - Quality Measures

### Clinical quality requirements

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure Name</th>
<th>Population</th>
<th>Population health priority</th>
<th>NQF #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric Health</strong></td>
<td>Well-Child Visits in the First 15 Months of Life</td>
<td>Pediatrics</td>
<td></td>
<td>1392</td>
</tr>
<tr>
<td></td>
<td>Well-Child visits in the 3rd, 4th, 5th, 6th years of life</td>
<td>Pediatrics</td>
<td></td>
<td>1516</td>
</tr>
<tr>
<td></td>
<td>Adolescent Well-Care Visits</td>
<td>Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weight assessment and counseling for nutrition and physical activity for children/adolescents, BMI assessment for children/adolescents</td>
<td>Pediatrics</td>
<td>Obesity, physical activity, nutrition</td>
<td>0024</td>
</tr>
<tr>
<td><strong>Women's Health</strong></td>
<td>Timeliness of prenatal care</td>
<td>Adults</td>
<td>Infant Mortality</td>
<td>1517</td>
</tr>
<tr>
<td></td>
<td>Live Births Weighing Less than 2,500 grams</td>
<td>Adults</td>
<td>Infant Mortality</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Postpartum care</td>
<td>Adults</td>
<td>Infant Mortality</td>
<td>1517</td>
</tr>
<tr>
<td></td>
<td>Breast Cancer Screening</td>
<td>Adults</td>
<td>Cancer</td>
<td>2372</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer screening</td>
<td>Adults</td>
<td>Cancer</td>
<td>0032</td>
</tr>
<tr>
<td><strong>Adult Health</strong></td>
<td>Adult BMI Assessment</td>
<td>Adults</td>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Controlling high blood pressure</td>
<td>Adults</td>
<td>Heart Disease</td>
<td>0018</td>
</tr>
<tr>
<td></td>
<td>Medication management for people with asthma</td>
<td>Both</td>
<td></td>
<td>1799</td>
</tr>
<tr>
<td></td>
<td>Statin Therapy for patients with cardiovascular disease</td>
<td>Adults</td>
<td>Heart Disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comprehensive Diabetes Care: HgA1c poor control (&gt;9.0%)</td>
<td>Adults</td>
<td>Diabetes</td>
<td>0059</td>
</tr>
<tr>
<td></td>
<td>Comprehensive diabetes care: HbA1c testing</td>
<td>Adults</td>
<td>Diabetes</td>
<td>0057</td>
</tr>
<tr>
<td></td>
<td>Comprehensive diabetes care: eye exam</td>
<td>Adults</td>
<td>Diabetes</td>
<td>0055</td>
</tr>
<tr>
<td></td>
<td>Follow up after hospitalization for mental illness</td>
<td>Both</td>
<td>Mental Health</td>
<td>0576</td>
</tr>
<tr>
<td></td>
<td>Preventive care and screening: tobacco use: screening and cessation intervention</td>
<td>Both</td>
<td>Substance Abuse</td>
<td>0028</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td>Initiation of alcohol and other drug dependence treatment</td>
<td>Adults</td>
<td>Substance Abuse</td>
<td>0004</td>
</tr>
</tbody>
</table>

*Measures will evolve over time*

- Measures will be refined based on learnings from initial roll-out
- Hybrid measures that require EHR may be added to the list of core measures
- Hybrid measures may replace some core measures
- Reduction in variability in performance between different socioeconomic demographics may be included as a CPC requirement
Antidepressant Medication Management

**Definition**
Percentage of patients ages 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and remained on an antidepressant medication treatment for at least 84 days (12 weeks).

**Important Notes**
Test, Service or Procedure to Close Care Opportunity:
- Diagnosis of major depression
- Patients who filled a prescription for an antidepressant medication
- Remained on medication 84 days
- Threshold: 47%
Follow-Up After Hospitalization for Mental Illness

**Definition**
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge.

**Important Notes**
Test, Service or Procedure to Close Care Opportunity:
• Diagnosis of mental illness upon discharge
• Must be seen by a licensed mental health provider within 7 days of discharge
• Must be face to face visit
• Threshold: 32%
Preventive Care and Screening: Tobacco Use

**Definition**
Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.

**Important Notes**
Test, Service or Procedure to Close Care Opportunity:
- At least two visits or at least one preventive visit during the measurement period
- Tobacco screen
- Tobacco cessation counseling intervention if identified as a tobacco user
- Threshold: 10%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

**Definition**
Percentage of patients 13 years and older with a new episode of alcohol or other drugs (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of their diagnosis.

**Important Notes**
Test, Service or Procedure to Close Care Opportunity:

- Diagnosis of drug or alcohol use
- Initiation of AOD treatment through:
  - Acute or non-acute inpatient stay, Stand-alone visits with an appropriate place of service code; Group visits with an appropriate place of service code
- Initiation of AOD treatment must take place within 14 days of the episode date **by you or a behavioral health provider**
- Threshold: 34%
Episodes of Care

• An “episode” payment is a single price for all of the services needed for an episode of care

• Goals:
  – Reduce incentive to overuse unnecessary services (ex: diagnostic labs)
  – Allow providers flexibility to decide which services should be delivered

• Behavioral Health Episodes:
  – Introduced in 3\textsuperscript{rd} Wave of Episodes
  – Conditions: ADHD, Oppositional Defiant Disorder
  – Reporting only 2017, Performance period in 2018
Retrospective episode model mechanics

1. Patients seek care and select providers as they do today
2. Providers submit claims as they do today
3. Payers reimburse for all services as they do today
4. Calculate incentive payments based on outcomes after close of 12 month performance period
5. Payers calculate average risk-adjusted reimbursement per episode for each PAP
6. Providers may:
   - Share savings: if average costs below commendable levels and quality targets are met
   - Pay negative incentive: if average costs are above acceptable level
   - See no impact: if average costs are between commendable and acceptable levels

- Review claims from the performance period to identify a ‘Principal Accountable Provider’ (PAP) for each episode
- Compare to predetermined “commendable” and “acceptable” levels
## Selection of episodes

### Principles for selection:
- Leverage episodes in use elsewhere to **reduce time to launch**
- Prioritize meaningful **spend across payer populations**
- Look for opportunities with clear **sources of value** (e.g., high variance in care)
- Select episodes that incorporate a **diverse mix** of accountable providers (e.g., facility, specialists)
- Cover a **diverse set of “patient journeys”** (e.g., acute inpatient, acute procedural)
- Consider **alignment with current priorities** (e.g., perinatal for Medicaid, asthma acute exacerbation for youth)

### Ohio’s episode selection:

<table>
<thead>
<tr>
<th>Episode</th>
<th>Principal Accountable Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WAVE 1 (launched March 2015)</strong></td>
<td></td>
</tr>
<tr>
<td>1. Perinatal</td>
<td>Physician/group delivering the baby</td>
</tr>
<tr>
<td>2. Asthma acute exacerbation</td>
<td>Facility where trigger event occurs</td>
</tr>
<tr>
<td>3. COPD exacerbation</td>
<td>Facility where trigger event occurs</td>
</tr>
<tr>
<td>4. Acute Percutaneous intervention</td>
<td>Facility where PCI performed</td>
</tr>
<tr>
<td>5. Non-acute PCI</td>
<td>Physician</td>
</tr>
<tr>
<td>6. Total joint replacement</td>
<td>Orthopedic surgeon</td>
</tr>
<tr>
<td><strong>WAVE 2 (launch January 2016)</strong></td>
<td></td>
</tr>
<tr>
<td>7. Upper respiratory infection</td>
<td>PCP or ED</td>
</tr>
<tr>
<td>8. Urinary tract infection</td>
<td>PCP or ED</td>
</tr>
<tr>
<td>9. Cholecystectomy</td>
<td>General surgeon</td>
</tr>
<tr>
<td>10. Appendectomy</td>
<td>General surgeon</td>
</tr>
<tr>
<td>11. Upper GI endoscopy</td>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>12. Colonoscopy</td>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>13. GI hemorrhage</td>
<td>Facility where hemorrhage occurs</td>
</tr>
<tr>
<td><strong>WAVE 3 (launch January 2017)</strong></td>
<td></td>
</tr>
<tr>
<td>14-19. Package of episodes including some related to behavioral health</td>
<td></td>
</tr>
</tbody>
</table>
Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average risk-adjusted reimbursement per provider)

- **Negative incentive**: No incentive payment
- **No change**: No incentive payment
- **No Change**: Eligible for positive incentive payment based on cost, but did not pass quality metrics
- **Positive incentive**:

Avg. risk-adjusted reimbursement per episode

$ [Bar chart showing distribution of reimbursement levels]

Acceptable

Commendable

Positive incentive limit

Principal Accountable Provider

**Ohio** Governor’s Office of Health Transformation

NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost
This is an example of the performance report format that will be released in 2016 with the launch of the performance period for Wave 1 and used for both Wave 1 and Wave 2 episodes in 2016.

### Episodic Name
Reporting period covering episodes that ended between Start Date to End Date
PAYER: Payer Name
PROVIDER ID: PAP ID
PROVIDER: Provider Name

### Eligibility requirements for gain or risk-sharing payments
- **Episode volume:** You have at least 5 episodes in the current performance period.
- **Spend:** Your average risk-adjusted spend per episode is below the commendable threshold.
- **Quality:** You are not currently eligible for gain-sharing because you have not passed all quality metrics linked to gain-sharing.
- **Note:** This report is informational only. Eligibility for gain or risk-sharing will be determined at the end of the performance period and any applicable payments will be calculated at that time.

### Episodes included, excluded & adjusted

<table>
<thead>
<tr>
<th># of episodes</th>
<th>Included</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Included</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Excluded</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quality metrics

- **You achieved # of # quality metrics linked to gain sharing**
  - Quality metric 01: 
    - #
    - %
  - Quality metric 02: 
    - #
    - %
  - Quality metric 03: 
    - #
    - %
  - Quality metric 04: 
    - #
    - %

### Risk adjusted average spend per episode

- **Distribution of provider average episode spend (risk adj.):**
  - Acceptable ($4,###)
  - Commendable ($#,###)
  - Gain sharing Limit ($#,###)

- **You are here:** $#,###

### Key performance

- **Rolling four quarters**
  - Performance period 2016:
    - Avg adjusted episode spend ($,000)
    - Q1 16
    - Q2 16
    - Q3 16
    - Q4 16
  - Performance period 2015:
    - Avg adjusted episode spend ($,000)
    - Q1 15
    - Q2 15
    - Q3 15
    - Q4 15
- **# of included episodes:**
  - #
  - #
  - #
  - #
- **Your spend percentile:**
  - #
  - #
  - #
  - #

### Disclaimer
The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports are neither intended nor suitable for other uses, including the selection of a health care provider. The figures in these reports are preliminary and are subject to revision. For more information, please visit [http://medicaid.ohio.gov/Providers/PaymentInnovation.aspx](http://medicaid.ohio.gov/Providers/PaymentInnovation.aspx).
## Wave 3: Behavioral health episode definition comparison table – quick reference

<table>
<thead>
<tr>
<th>PAP</th>
<th>Trigger</th>
<th>Valid ages</th>
<th>Duration</th>
<th>Quality metrics&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider with the plurality of ADHD-related E&amp;M and medication management visits when applicable</td>
<td>Professional claim with diagnosis of AD/ADHD</td>
<td>4-20 years old</td>
<td>180 days&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Percentage of valid episodes that meet the minimum care requirement of five visits/claims during the episode window. Percentage of valid episodes with no coded behavioral health comorbidity for which the patient received antipsychotics, Percentage of valid episodes of patients ages 6 to 12 for which there was a follow-up visit within 30 days of a prescription for ADHD medication, Percentage of valid episodes of patients ages 3 to 5 that include any BH medication</td>
</tr>
</tbody>
</table>

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<sup>1</sup> The episode window is 180 days; it is not divided into trigger/post-trigger windows.

<sup>2</sup> Italicics indicate quality metrics not tied to gain-sharing; not exhaustive
Episodes of Care - Resources

Episode quick reference tables - A summary of key episode definition components for all episodes.

Detailed episode information
Definitions or concept papers, Detailed Business Requirements (DBR), and code tables for all episodes. Concept papers include an overall introduction to the episode rationale and design dimensions. DBRs include a more detailed definition as well as the associated coding algorithm. The code tables refer to an excel spreadsheet with the code detail for each episode.

Wave 1: Reporting for the initial set of episodes began in March of 2015. For Medicaid, the performance period for asthma, COPD, and perinatal begins January 1st, 2016. Episodes ending during the 12-month performance period will be used to determine whether or not a provider is eligible for an incentive payment. Reporting will continue for all episodes.

- Asthma (definition, DBR, code sheet, thresholds)
- COPD (definition, DBR, code sheet, thresholds)
- Perinatal (definition, DBR, code sheet, thresholds)
- Acute percutaneous coronary intervention episodes (definition, DBR, code sheet)
- Non-acute percutaneous coronary intervention episodes (definition, DBR, code sheet)
- Total joint replacement (definition, DBR, code sheet)
Special Programs

- Ohio Re-entry Program (ORP)
- Coordinated Services Program (CSP)
- Community Transitions Program (CTP)
- Addiction Treatment Program (ATP)
Offender Re-entry Program

- The Goal of the Offender Re-entry Program is to facilitate the transition of care from the corrections system to the community.
- MCO CMs work with POC’s at all 28 ODRC Facilities.
- 12,835 Offenders have participated in the initiative since it started in 2014.
- Eligibility includes any 2 of the following:
  - SMI, SUD, Chronic Condition, HIV, Hepatitis C
Offender Re-entry Program

• Medicaid Eligibility 30-60 days prior to release
• CMs conduct video conferences with Offenders prior to release
• Community Linkage biopsychosocial assessment provided for those inmates with an SMI diagnoses
• Appointments are scheduled prior to release
• Post-Release contact attempts are made within 5 days of release date
Coordinated Services Program
5160-20-01

• Goal of CSP is to assist Members in obtaining only medically necessary services
  – A member may be enrolled if a review of utilization demonstrates a pattern of receiving services at a frequency or in an amount that exceeds medical necessity

• All Members enrolled in CSP are eligible for all services covered by Medicaid as defined in division 5160-1-01 of the Administrative Code
Coordinated Services Program

- Reasons for enrollment in CSP:
  - use of multiple pharmacies
  - use of multiple controlled substances
  - multiple visits to emergency rooms
  - a high volume of prescriptions or visits to medical professionals
  - previous enrollment in CSP
  - demonstrating fraudulent or abusive patterns of medical services utilization
Coordinated Services Program

- Thirty days prior to enrollment MCO sends:
  - ✓ Member Notification letter
  - ✓ CSP Brochure
  - ✓ Notice of Proposed Enrollment with state hearing form
- Members have 90 days to request a state hearing
  - ✓ within 15 days
  - ✓ greater than 15 days
Coordinated Services Program

• Initial enrollment is for (24) months
  ✓ Issued CSP Member ID card

• Continued enrollment
  ✓ If utilization still supports the reasons for enrollment, enrollment can continue for up to 24 more months

• Disenrollment
  ✓ If after 24 month enrollment period utilization no longer supports the reasons for enrollment the Member will be disenrolled
  ✓ If a Member in CSP enters a long-term care facility or Hospice program, the Member will be disenrolled
  ✓ Issued Non-CSP Member ID card
Community Transitions Program

• RFP awarded to CareSource July, 2016
• Targeted to those individuals leaving prison with a SUD
• Services Include: access to housing, vocational services, SUD counseling, peer support and other recovery services
Community Transitions Program

• The goal of this initiative is to ensure returning citizens receive the most efficient and supportive re-entry experience by enhancing care coordination between the institution, providers, parole and managed care.
Community Transitions Program

• 1637 active members
• 27% have co-morbid MH diagnosis
• 81% male, 19% female
• 62% Caucasian, 34% African American, 1.4% Hispanic
• 66 contracted providers
• 274 locations in 66 counties
Addiction Treatment Program (ATP)

- Legislatively Established in Section 331.90 of the Am. Sub. H.B. No. 64.
- Ohio MHAS shall conduct a program in select counties providing addiction treatment to individuals who are offenders within the criminal justice system, eligible to participate in MAT drug court, and with dependence on opioids, alcohol, or both.
- Expectation that treatment provider & court personnel be able to serve more people due to the ability to get more people enrolled in Medicaid or commercial insurance in a timely manner.
Addiction Treatment Program (ATP)

- Recovery supports are a form of assistance intended to help an individual with addiction or mental health needs, or a member of the family of such an individual, to initiate and sustain the individual's recovery from alcoholism, drug addiction, or mental illness.

- Examples include, but are not limited to:
  - Housing
  - Transportation
  - Childcare
  - Employment
  - Identification (i.e. birth certificates, drivers licenses, social security card)
  - Non-Vocational Education (i.e. parenting classes, life skills, self-care)
Addiction Treatment Program (ATP)

• Provide addiction treatment and therapy, including Medication-assisted treatment (MAT).
  o May use long-acting antagonist or partial agonist medications or both.
  o Must be FDA approved for treating alcohol and/or opioid dependence.
  o Provide other types of therapies and supports for co-occurring disorders.
• Full agonist medications (Methadone) are not eligible
Addiction Treatment Program (ATP)

• Expansion of drug courts to 22 counties
• Link more consumers with Medication Assisted Treatment (MAT)
• Minimize administrative barriers to MAT for consumers assigned to a MCP
• Formalize a communication process between MCPs and the drug courts
Participant Eligibility

• Person is actively engaged with a certified Ohio drug court, that also provides MAT to appropriate individuals located in one of the following counties:
ATP Counties - FY 16 and 17

- Allen
- Hamilton
- Mercer
- Clinton
- Hardin
- Montgomery
- Cuyahoga
- Hocking
- Summit
- Franklin
- Jackson
- Warren
- Gallia
- Marion
Counties Added in FY 17:

• Butler
• Lorain
• Stark
• Clermont
• Lucas
• Trumbull
• Lake
• Mahoning
Appropriated $11 Million in SFY 16/17 for treatment, medication, evaluation and oversight.

Initial distribution based on six-month projection beginning January 2016. Ohio MHAS may adjust future funding based on actual utilization.

Provider distribution is based on local collaboration of ADAMHS boards, courts and providers.

Funding model based on $2,000 per monthly slot, no reconciling to actual services provided.

Slots available in each county can be found on the Ohio MHAS website.
## How To Contact Us

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