Managed Care – Lessons Learned from BH Redesign and Integration
Topic Areas...

- Lessons Learned
- ASAM & Coordination of Care
- Value Based Contracting
  - Episodes of Care
  - CPC/BHCC
- Specialty Programs
- How to Contact Us
Lessons Learned

1. Providers need information in advance on Medicaid initiatives for strategic planning
2. MCOs can help bridge the communication gap with Medicaid
3. Understanding MCO requirements can help providers with strategic planning
The ASAM Criteria - Guiding Principles for Coordination of Care

1. **Outcome-driven Treatment** vs. **Program-driven Treatment**
2. **Variable Length of Stay** vs. **Fixed Length of Stay**
3. **Goals** as the mainstay of Treatment
4. **Interdisciplinary Team Approach**
5. **Medical Necessity** Clarification
6. **Multidimensional Assessment** vs. one-dimensional assessment

The ASAM Criteria Book – P. 3
ASAM Criteria 7-Steps

1. Bio-Psychosocial Assessment
2. ASAM (6)-Dimensional Analysis
3. Risk Assessment
4. Driving Dimensions Identified
5. **Level of Care (LOC) Placement**
6. Problem List Creation
7. Individual Treatment Plan (ITP) Created

Step 5 – Level of Care Placement

Appropriate Level of Care (LOC) placement is decided by (3) Components:

1. **The Driving Dimensions** (Step 4) and
2. **The ASAM Dimension Rules &**
3. **The ASAM Crosswalk**

*Note: The crosswalk and dimensions rules are used for LOC Placement NOT for Continued Stay determination...*
Level of Care Placement is based on 3 things:

1. The ASAM 6-Dimensions
2. The ASAM Crosswalk
3. The ASAM Dimension Rules
ASAM Criteria 7-Steps

1. Bio-Psychosocial Assessment
2. ASAM (6)-Dimensional Analysis
3. Risk Assessment
4. Driving Dimensions Identified
5. Level of Care (LOC) Placement
6. Problem List Creation
7. **Individual Treatment Plan (ITP) Created**

**Step 7 – Individualized Treatment Plan**

Includes documentation of the following:

- **Measurable Criteria** and achievable reduction or resolution of problems (**Goals**)
- List of the actions the patient will take (**Objectives**)
- The treatment services provided by the program (**Modalities**)
- The staff responsible for delivering treatment (**Interventions**)
- A timeline for completion of treatment (**Target deadline dates**)
Continued Stay Criteria

**Is based on:**

**The Individualized Treatment Plan:**

1. Patient Progress
2. Non-progress, or
3. New problems

The ASAM Criteria Book – P. 300

| Dates: | Initial Tx Plan Date: ____________  
|        | Tx Plan Review Date: # 1 _______  
|        | Tx Plan Review Date: # 2 _______  
|        | Tx Plan Review Date: # 3 _______  | Target Dates of Completion |
| Staff Present: | Name, Credentials – Title  
|                | Susan Brown, LCDC – Primary Counselor | NA |
| Problem Statement A&B | List the problems that brought the patient into treatment.  
|                       | As Evidenced By:  
|                       | List of concrete examples of the problem; | NA |
| Stage of Change A&B | Pre-Contemplation - Contemplation  
|                     | Preparation - Action - Maintenance  
|                     | As Evidenced By:  
|                     | Give example statements of the patient response when presented with the problem statement and concrete examples | NA |
| Goal Statement A&B | Goal # 1  
|                    | Actions that will let you know the problem has been addressed.  
|                    | As Evidenced By:  
|                    | Give concrete examples of what you will need to see before you can verify the problem has been fixed | Start Date 1/1/19  
|                    | Target Date 1/30/19  
|                    | Completed:  
|                    | Continued:  
|                    | Date | |
| Measurable Steps: “what the Patient will do” | Objective 1A  
|                   | Assigned actions the patient will do (learn, list, verbalize) for him/her to complete the goals | Start Date 1/1/19  
|                   | Target Date 1/7/19  
|                   | Completed:  
|                   | Continued:  
|                   | Date | NA |
| Specific Actions: “what the Counselor will do” | Intervention 1A  
|                  | Actions the staff will do (teach, monitor, assign readings) to assist the patient in completing his/her objectives  
|                  | Name of the Responsible Staff assigned each objective | Start Date 1/1/19  
|                  | Target Date 1/7/19  
|                  | Completed:  
|                  | Continued:  
|                  | Date | NA |
ASAM Continued Stay Criteria

There remains much confusion regarding criteria for Continued Stay...

• The 2013 Version of The ASAM Criteria book suggests that it is the patient status in the ASAM Six (6) Dimensional Assessment

• The 2018 Version of the ASAM Skill-building Training Journal clearly states that is the Progress or Non-progress on the treatment plan as evidenced by:
  1. Completion of goals & objectives and/or;
  2. The onset of new problems affecting the person’s recovery
Evidence for ASAM Continued Stay Criteria #1 (2018 Version)

• The **Length of Stay** (Service) should be based on the progress the patient is making – ASAM Skill-building Training Journal – p. 10

• **Achievement of Goals in the Tx Plan determine the Length of Stay** – ASAM Skill-building Training Journal – p. 37

• The clinician uses the **6-Multidimensional Assessment** to formulate the **initial treatment plan, problems, goals and objectives** – ASAM Skill-building Training Journal – p. 14

   ASAM Skill-building Training Journal – **2018 Version**
Evidence for ASAM Continued Stay Criteria #2 (2018 Version)

- Track progress on goals, objectives and methods with progress notes – ASAM Skill-building Training Journal – p. 32

- Summarize treatment plan progress with Continued Stay Reviews – ASAM Skill-building Training Journal – p. 32

- Transfer or Discharge if; goals are achieved or unable to resolve problems despite amendments to the treatment plan – ASAM Skill-building Training Journal – p. 33

ASAM Skill-building Training Journal – 2018 Version
Continued Stay Request – MCO Universal PA form

Instructions for SUD Service Requests

- Include admission date and referral source along with reason for admission
- Provide primary/secondary diagnoses and psychosocial issues/barriers to treatment
- Indicate whether the admission was court ordered
- Identify Level of Care requested and provide documentation of medical necessity using ASAM criteria
- Provide pertinent medical and BH history including SI/HI risk
- Provide treatment plan with target dates and discharge plan
- For continued stay requests please provide: updated ASAM LOC documentation, any new problems identified, an update on the treatment plan including how lack of progress is being addressed in any areas, updated discharge plan, updated information on psychosocial barriers, and MAT status.

**Providers should attach clinical documentation (e.g. Assessment Summary, ISP with Diagnostic Summary, Clinical Summary) to provide justification that the member meets criteria for a service. Services marked with an asterisk (*) may require additional assessment results to be provided (e.g. ANSA, CANS [including CIP-IHBT version]. Achenbach).**
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 (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 (CPC/BHCC)
  - Episodes of Care (upside/downside risk)
Ohio’s Value-Based Alternatives to Fee-for Service

Ohio’s State Innovation Model (SIM) focuses on (1) increasing access to comprehensive primary care and (2) implementing episode-based payments.

Fee for Service: Payment for services rendered
Pay for Performance: Payment based on improvements in cost or outcomes
Patient-Centered Medical Home: Payment encourages primary care practices to organize and deliver care that broadens access while improving care coordination, leading to better outcomes and a lower total cost of care
Episode-Based Payment: Payment based on performance in outcomes or cost for all of the services needed by a patient, across multiple providers, for a specific treatment condition
Accountable Care Organization: Payment goes to a local provider entity responsible for all of the health care and related expenditures for a defined population of patients
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 3rd Wave of Episodes
  – Conditions: ADHD, Oppositional Defiant Disorder
  – Reporting only 2017, Performance period in 2018
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>
Episodes of Care

1. Patients and providers continue to deliver care as they do today.
   - 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.
   - Review claims from the performance period to identify a ‘Principal Accountable Provider’ (PAP) for each episode.

5. Payers calculate average risk-adjusted reimbursement per episode for each PAP.
   - Compare to predetermined “commendable” and “acceptable” levels.

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
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**: Principal Accountable Provider

Avg. risk-adjusted reimbursement per episode

Acceptable

Commendable

Principal Accountable Provider

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

CPC and BHCC 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 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: Overseas 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 BHCC program gives practices access to data and reports that provide actionable, timely information needed to make better decisions about outreach, care and referrals.
BHCC - Quality Measures

Behavioral Health Care Coordination Quarterly Progress Report
Qualified entity ABC (9999999)
Reporting period only

Behavioral Health Care Coordination performance summary
July 2020 – Sept 2020

This reporting period includes services delivered between 1/1/2019 and 12/31/2019, and paid through 12/31/2019

Behavioral Health Care Coordination: Measure Summary (1/2)

<table>
<thead>
<tr>
<th>Quality measures tied to eligibility</th>
<th>Meeting 13 of 18 quality measures Performance</th>
<th>Trend</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Health</td>
<td></td>
<td></td>
<td>245%</td>
</tr>
<tr>
<td></td>
<td>Adult BMI Assessment</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Controlling High Blood Pressure</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Diabetes Care: HbA1c Testing</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Diabetes Care: Poor Control (HbA1c &gt;9%)</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Diabetes Care: Eye Exam</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Tobacco Use: Screening &amp; Cessation</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Follow-up After Hospitalization for Mental Illness, 7-day</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence, 7-day</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Follow-up After Emergency Department Visit for Mental Illness, 7-day</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Antidepressant Medication Management – Effective Continuation Phase Treatment</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Initiation &amp; Engagement of Alcohol and Other Drug Dependence Treatment: Engagement</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Metabolic Monitoring for Children and Adolescents on Antipsychotics</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Use of Multiple Concurrent Antipsychotics in Children &amp; Adolescents</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Adolescent Well-Care Visits</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children / Adolescents: BMI Documentation</td>
<td>N/A</td>
<td>▲</td>
</tr>
<tr>
<td>Women’s Health</td>
<td></td>
<td></td>
<td>245%</td>
</tr>
<tr>
<td></td>
<td>Percent of Live Births Weighing Less Than 2,500 Grams</td>
<td>XX</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Prenatal &amp; Postpartum Care: Timeliness of Prenatal Care</td>
<td>N/A</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Prenatal &amp; Postpartum Care: Postpartum Care</td>
<td>XX</td>
<td>▲</td>
</tr>
</tbody>
</table>

Behavioral Health Care Coordination: Measure Summary (2/2)

<table>
<thead>
<tr>
<th>Opioid-related</th>
<th>Use of opioids at high dosage (&gt;80 MED / day)</th>
<th>N/A</th>
<th>N/A</th>
<th>XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency measures tied to eligibility</td>
<td>Meeting 3 of 3 efficiency measures Performance</td>
<td>Trend</td>
<td>Threshold</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>Emergency Department Visits / 1,000</td>
<td>N/A</td>
<td>▲</td>
<td>XX</td>
</tr>
<tr>
<td>BH-Related IP Admits / 1,000</td>
<td>XX</td>
<td>▲</td>
<td>XX</td>
<td></td>
</tr>
<tr>
<td>IP Discharges / 1,000</td>
<td>XX</td>
<td>▲</td>
<td>XX</td>
<td></td>
</tr>
<tr>
<td>All-Cause 30-day Readmissions</td>
<td>XX</td>
<td>▲</td>
<td>XX</td>
<td></td>
</tr>
</tbody>
</table>

Top 10 primary care practices where your attributed measurements are in range:

<table>
<thead>
<tr>
<th>Practice name</th>
<th>Location</th>
<th>% of panel with visit</th>
<th>Avg visits / member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice 1</td>
<td>1134 Whittier Ave, Columbus, OH</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Practice 2</td>
<td>NP 1</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Practice 3</td>
<td>NP 2</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Practice 4</td>
<td>NP 3</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Practice 5</td>
<td>NP 4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Practice 6</td>
<td>NP 5</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Practice 7</td>
<td>NP 6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Practice 8</td>
<td>NP 7</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Practice 9</td>
<td>NP 8</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Practice 10</td>
<td>NP 9</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

1. Practices compiled at the organizational Medicaid ID level.
Quarterly Progress Report – Opioid Analytics

### Behavioral Health Care Coordination Quarterly Progress Report
Qualified entity ABC (99999999)
Reporting period only

#### Opioid-related member panel characteristics
Januay – December 2016

This report divides your attributed member population into four levels along the OUD4 risk pathway:
- Level 1: Members at little to no risk for OUD
- Level 2: Members at moderate risk for OUD
- Level 3: Members at high risk for OUD
- Level 4: Members diagnosed with OUD

#### Change in attributed OUD member risk

<table>
<thead>
<tr>
<th>Year</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2016</td>
<td>18%</td>
<td>33%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>CY 2015</td>
<td>21%</td>
<td>36%</td>
<td>8%</td>
<td>36%</td>
</tr>
</tbody>
</table>

#### Key opioid-related statistics about your member panel by risk level

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of opioid prescriptions per member</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
</tr>
<tr>
<td>Average MED3 / day per member</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
</tr>
<tr>
<td>Average number of MAT prescriptions</td>
<td>0</td>
<td>0</td>
<td>X.X</td>
<td>X.X</td>
</tr>
<tr>
<td>Number of prescribers visited for opioids per member</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
</tr>
<tr>
<td>Number of pharmacies visited for opioids per member</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
</tr>
<tr>
<td>Percent of members with non-opioid SUD</td>
<td>X.X%</td>
<td>X.X%</td>
<td>X.X%</td>
<td>X.X%</td>
</tr>
<tr>
<td>Average distance travelled to pharmacies for opioids (miles)</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
<td>X.X</td>
</tr>
</tbody>
</table>

#### OUD risk factors by member level
Januay – December 2016

This reporting period includes services delivered between 1/1/2016 and 12/31/2016, and paid through 6/30/2017

| Risk factors for developing OUD by prevalence in attributed member population |
|--------------------------------------------------|------------------|------------------|------------------|------------------|
| Percent of members with risk factor by level     | Level 1 | Low density | Level 2 | Level 3 | High density |
| Demographics: Between 20 and 39 years old       | XX% | XX% | XX% | XX% | XX% |
| Limitations on activities of daily living       | XX% | XX% | XX% | XX% | XX% |
| Pain diagnosis: Chronic pain                     | XX% | XX% | XX% | XX% | XX% |
| Low back pain                                   | XX% | XX% | XX% | XX% | XX% |
| Mental Health: PTSD                             | XX% | XX% | XX% | XX% | XX% |
| Overdose by substance use*                      | XX% | XX% | XX% | XX% | XX% |
| Illicit use*                                    | XX% | XX% | XX% | XX% | XX% |
| Non-opioid substances: Prescribed benzodiazepines | XX% | XX% | XX% | XX% | XX% |
| Prescribed sedatives/hypnotics                   | XX% | XX% | XX% | XX% | XX% |
| Opioids days supply > 211*                      | XX% | XX% | XX% | XX% | XX% |
| Opioids and benzodiazepines concurrent use       | XX% | XX% | XX% | XX% | XX% |
| Opioid prescriptions >= 4*                       | XX | XX | XX | XX |
| Visiting 4+ pharmacies for opioids*              | XX% | XX% | XX% | XX% | XX% |
| Visiting 4+ prescribers for opioids*             | XX% | XX% | XX% | XX% | XX% |
| Average MED/day > 120*                          | XX% | XX% | XX% | XX% | XX% |

* Factors statistically significant in predicting OUD in Ohio Medicaid population
2 opioids-related interactions for level 4 only cover the period following their first OUD diagnosis based upon available claims data.

---

ILI <IL>

---

DRAFT
Special Programs
(Opportunities for Partnership)

- Offender 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 Care Managers work with all 28 ODRC Facilities.
- 33,500+ 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
• 23% engage in the Care Management program after release
Coordinated Services Program
5160-20-01

• 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
  ✓ demonstrating unsafe patterns of pharmacy utilization
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
  – MCOs must offer care management services to enrollees to assist with coordination of medically necessary services
Addiction Treatment Program (ATP)

- Provide addiction treatment and therapy to offenders within the criminal justice system eligible for Drug Court, including Medication-assisted treatment (MAT):
  - May use long-acting antagonist or partial agonist medications or both.
  - Must be FDA approved for treating alcohol and/or opioid dependence.
  - 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
## How To Contact Us

<table>
<thead>
<tr>
<th>Plan</th>
<th>Primary Contact</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>BUCKEYE</td>
<td>Laura Paynter</td>
<td>(216) 643-1846</td>
<td><a href="mailto:lpaynter@centene.com">lpaynter@centene.com</a></td>
</tr>
<tr>
<td>CARESOURCE</td>
<td>Terry R. Jones</td>
<td>(937) 286-3985</td>
<td><a href="mailto:Terry.Jones@caresource.com">Terry.Jones@caresource.com</a></td>
</tr>
<tr>
<td>MOLINA</td>
<td>Emily Higgins</td>
<td>(614) 212-6298</td>
<td><a href="mailto:Emily.Higgins@MolinaHealthcare.com">Emily.Higgins@MolinaHealthcare.com</a></td>
</tr>
<tr>
<td>PARAMOUNT</td>
<td>Linda Nordahl</td>
<td>(419) 887-2279</td>
<td><a href="mailto:Linda.nordahl@promedica.org">Linda.nordahl@promedica.org</a></td>
</tr>
<tr>
<td>UNITED</td>
<td>Tracey Izzard-Everett</td>
<td>(614) 410-7952</td>
<td><a href="mailto:tracey.izzard-everett@optum.com">tracey.izzard-everett@optum.com</a></td>
</tr>
</tbody>
</table>