Ohio | Department of Medicaid

Next Generation of Ohio Medicaid's Managed Care Program

Listening Session 2.0 Meetings

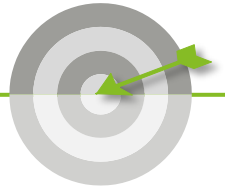
Next Generation of Ohio Medicaid's Managed Care Program

Today's Agenda and Objectives

Listening Session 2.0 Agenda

	Topic
1	Agenda and Objectives
2	Overview: Next Generation of Ohio Medicaid
3	2022 Member Transition Enrollment
4	Communication to Ohio Medicaid Members
5	Unwinding: COVID-19 Public Health Emergency (PHE) Declaration
6	Interactive Discussion
7	What's Next?

Session Objectives



- Provide an overview of the **next generation Ohio Medicaid program** for members
- Share the **2022 Member Transition Enrollment process and timeline**, and what members will need to do and when
- Solicit **feedback for how to best communicate to members** and resources or information that would be helpful to assist members in choosing a plan
- Prepare community organizations **for future engagement and participation expectations**

Overview: Next Generation of Ohio Medicaid

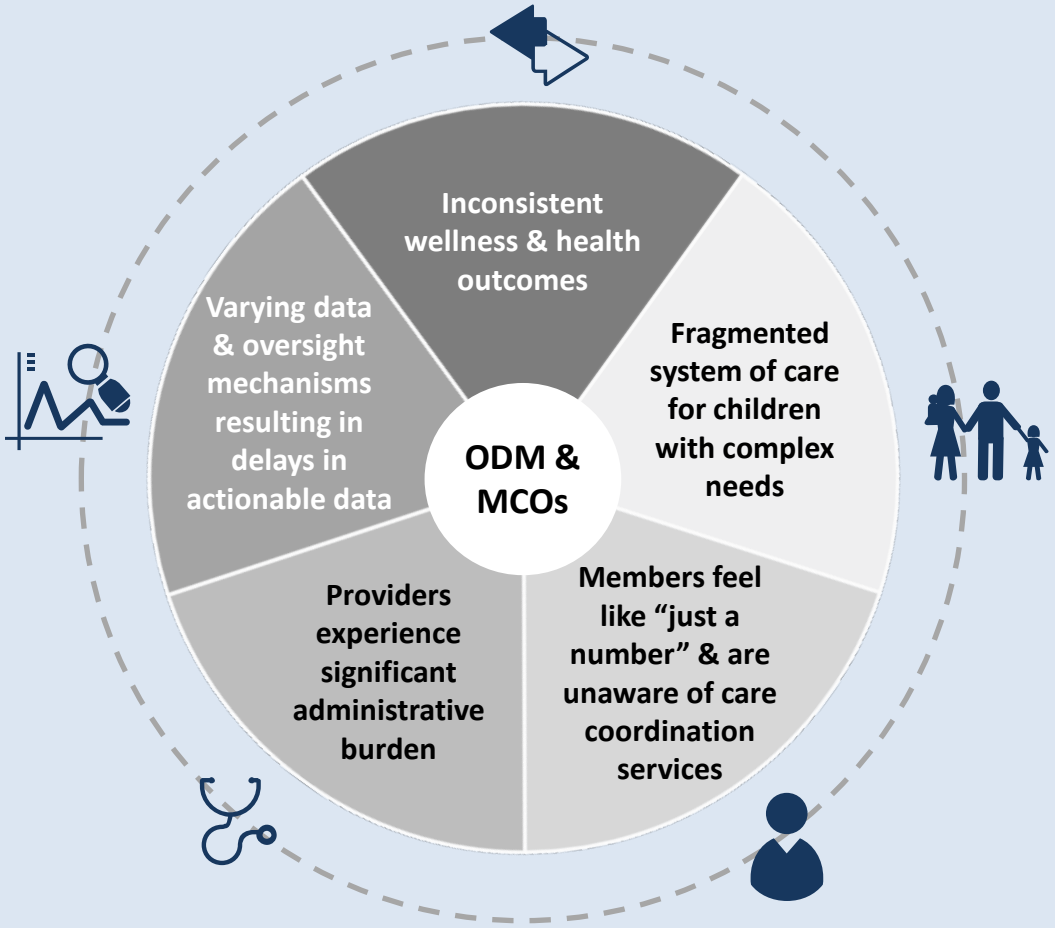
Ohio's Next Generation Medicaid Program

Mission Statement

Ohio's Medicaid Managed Care Program

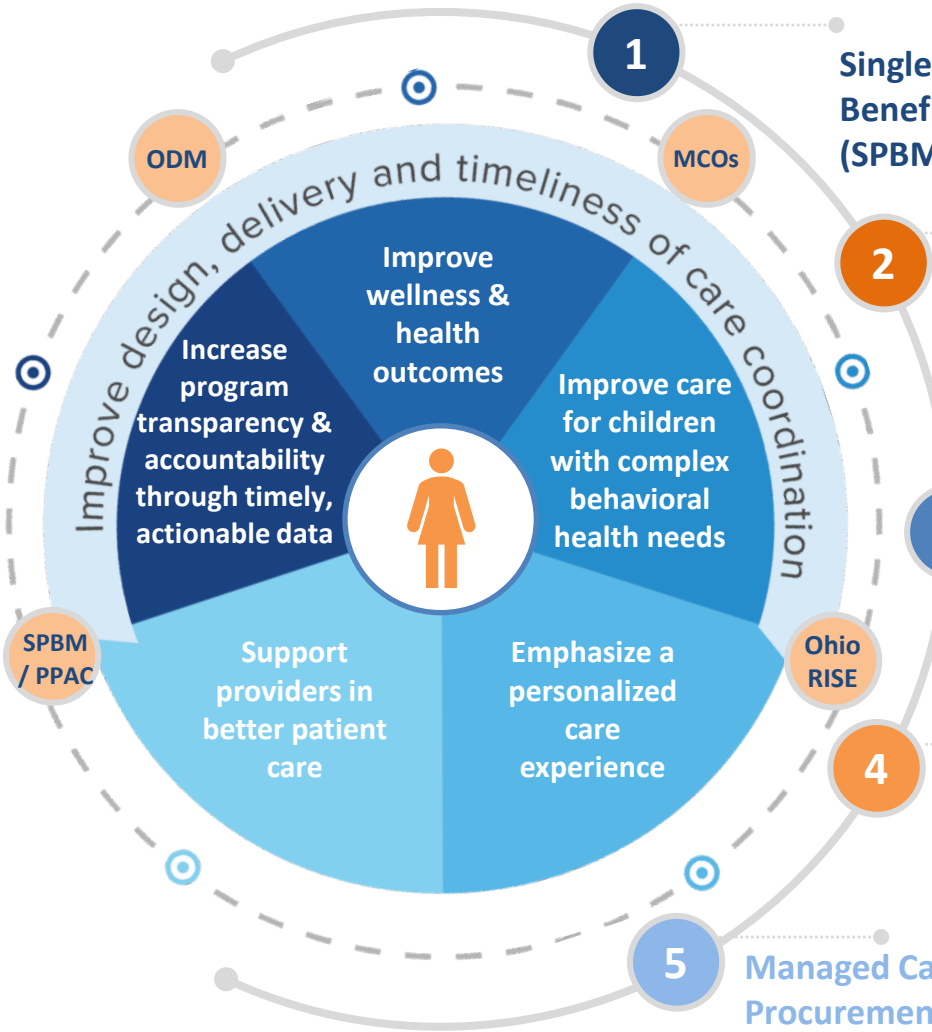
Today's Ohio Medicaid Managed Care Program

Members are impacted by business decisions that don't always take their needs or circumstances into consideration. Providers are not always treated as partners in patient care. We want to do better for the people we serve.



"Next Generation" of Ohio Medicaid

The focus is on the individual with strong coordination and partnership among MCOs, vendors & ODM to support specialization in addressing critical needs.



Our Path Thus Far

Starting with the voice of members and providers

Focusing on the INDIVIDUAL rather than the business of managed care

We began by soliciting input and suggestions from members and providers

119 Medicaid members participated in in-person listening sessions

36 Community partner organizations hosted listening sessions

17 Listening sessions hosted across the state

Requests for Information

Through two RFIs, we…

Received **over 1,000** pieces of feedback from providers, members & advocates

Met with more than 50 providers and provider associations

The Framework for Updating Ohio's Medicaid Managed Care Program

First Generation Program Gaps
Feedback highlighted challenges with the current program – many of which the state is constrained in addressing under the current Medicaid Provider Agreement.

Creation of a New Contract
New Provider Agreement aimed at addressing these issues and creating the "next generation" of the program.

Changing the Status Quo
Created more levers to position ODM to better adapt & respond to the constantly changing healthcare needs of Ohioans.

Procurement Process
Issued new Managed Care Entity (MCE) contracts to seven managed care plans, the OhioRISE plan and the single pharmacy benefit manager.

Next Generation of Ohio Medicaid

Improve design, delivery and timeliness of care coordination

Goals of the Next Generation of Ohio Medicaid

OhioRISE Transition and Enrollment

Timeline

FEBRUARY 2022

Care Management Entities (CMEs) Selected

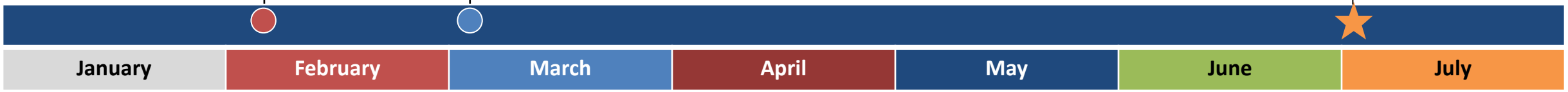
Aetna OhioRISE Listening Sessions

MARCH 2022

Intensive Home-Based Treatment (IHBT) Enhanced Rule Effective

JULY 1, 2022

OhioRISE Go-live



FEBRUARY 2022 & BEYOND

Community and Provider Training Opportunities

JANUARY 2022 & BEYOND

- Advisory Council and Implementation & Operations Workgroup
- Support and Expand MRSS Providers
- Launch CMEs

*PRTF Service begins in January 2023

OhioRISE Status Update

What We've Accomplished to Date*

40

Advisory Council (AC) and Workgroup Meetings facilitated since January 2021

80-120+

Average number of attendees in every AC and Workgroup meeting

30

Number of presentations given on OhioRISE Roadshow

35

Rules drafted or updated and sent for public comment

500+

Comments received on OHR service rules from the AC and Workgroup members

664

Total Ohio Children's Initiative CANS Certified Assessors

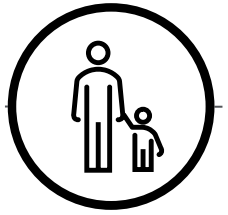
*From January 1, 2021 – January 21, 2022

Next Generation Activities

Activities occurring over the next few months

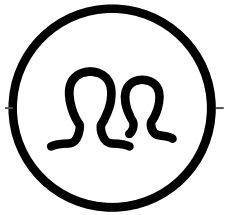
Today's Focus

SPBM / PPAC



OhioRISE

Managed Care



Fiscal Intermediary

Centralized Credentialing

Member Transition & Enrollment

Transition and enrollment in the next generation managed care plans

2022 Member Transition Enrollment

Member Transition & Enrollment Approach

2022 Member Transition & Enrollment

ODM is encouraging members to select a next generation MCO and honoring those selections

1. Choice: From March 1 thru Nov. 30th. Household Continuity & Continuity of Care Providers
2. MCO Weighting: New, Hybrid & Incumbent Plans
3. Fee for Service (FFS) Pool Prior to Go-Live
4. December Assessment & Possible Adjustments

Member Transition & Enrollment Approach

Serving the member by prioritizing member choice

1 Choice: From March 1 thru Nov. 30th.

All members will be encouraged through a comprehensive, ODM-led communications and outreach campaign to actively select a next generation MCO that best meets their healthcare needs *and* can change without cause until Nov. 30, 2022.

AmeriHealth Caritas — Care is the heart of our work

Anthem

buckeye health plan

CareSource

Humana

MOLINA HEALTHCARE

UnitedHealthcare Community Plan

Member Transition & Enrollment Approach

Serving the member by prioritizing family and household continuity

1 Household Continuity

- Next generation MCO assignments will be based on a **common provider network** for the member and among the household
- **Deemed newborns** – Newborns are assigned to the same plan as their mother
- **Addition to a family/household** – Individuals who are added to a case with other individuals that are currently enrolled in a plan are assigned to the same plan

Member Transition & Enrollment Approach

Serving the member by supporting continuity of care

1 Continuity of Care Providers

- Currently enrolled members in the continuing plans will **remain in their current plan at go-live**, unless the member selects a different next generation plan
- In December, **an assessment** will be made to determine if any currently enrolled members need to be transitioned to a new MCO
- Currently enrolled members in the continuing plans that have **heightened needs**, including individuals with known high-risk conditions, whether they are being treated or not, **are excluded from the possibility of reassignment**
- If a member is transitioned to a different MCO, **the impact on the member continuity of care will be minimized** through a provider utilization review

New, Hybrid & Incumbent Plans

2022 Member Transition & Enrollment

2 MCO Weighting: New, Hybrid & Incumbent Plans

As a part of ODM's transition to and implementation of the next generation program, Medicaid managed care members will have the opportunity in Spring 2022 to select a plan from one of the seven next generation MCOs and will have the option to change through November 30th.

Current MCOs remaining in the Next Generation program

Continuing MCOs

- Buckeye Community Health Plan
- CareSource Ohio, Inc.
- Molina Healthcare of Ohio, Inc.
- UnitedHealthcare Community Plan of Ohio, Inc.

MCOs joining the Next Generation Program on July 1, 2022

New MCOs

- AmeriHealth Caritas Ohio, Inc.
- Humana Health Plan of Ohio, Inc.

Hybrid MCO

- Anthem Blue Cross and Blue Shield
  - *New SE/E. Paramount regions: W & NE*

Member Transition & Enrollment | FFS "Pool" Prior to Go-Live

During member transition and enrollment, certain populations will receive care paid for through Medicaid FFS until they are transitioned into a next generation plan July 1, 2022

3 Fee for Service (FFS) Pool Prior to Go-Live

Who is included in this period?*	• Ohio Medicaid members newly eligible Medicaid and managed care • Ohio Medicaid members currently in FFS not enrolled with an MCO • Members with an Ohio Medicaid eligibility gap of 91+ days
What is Medicaid FFS?	• Members in Medicaid FFS are not in a managed care plan • Members in FFS can receive services from any provider that accepts Ohio Medicaid
What program is care through?	• Receive care paid for through Medicaid fee-for-service (FFS) through June 30, 2022 • Transition to a next generation managed care plan July 1, 2022

*Newborns and case additions will continue to be added to managed care plans as they become Medicaid eligible during this time

December Assessment & Adjustments, if needed

Serving the member by supporting continuity of care

4 December Assessment & Possible Adjustments

- Currently enrolled members in the continuing plans will **remain in their current plan at go-live**, unless the member selects a different next generation plan
- **December assessment:** determine if any currently enrolled members need to be transitioned to a new MCO
- **Exclusions:** Members who will not be considered for transfer
  - Anyone who has made a **choice**
  - Currently enrolled members who have **heightened needs**, including known high-risk conditions, whether they are being treated or not, **are excluded from the possibility of reassignment.** See next slide for examples.
- For members identified for transfer to another MCO, **continuity of care providers will be optimized**
- Once the member is notified that they are to be transferred to another MCO:
  - Members have 60 days to say “no” and have no change in their plan
  - In February 2023, when their new plan is effective, members have an additional 90 days to request a change in managed care plans

Examples of Members

Who would not be considered for transfer to another MCO

- Individuals with serious mental illness
- Individuals with OUD with or without recent claims
- Individuals served on HCBS waivers
- Individuals who rely on technology (vent use or private duty nursing)
- Individuals who rely on in-home staffing
- Individuals with high-risk conditions that need regular access to care
- Children and youth in foster care or adoption assistance
- Individuals with active care management from MCO
- Pregnant women/postpartum with or without recent claims
- Individuals with a recent psych hospitalizations
- Individuals with a cancer diagnosis with or without recent claims
- Individuals in MCO coordinated services program

Member Transition & Enrollment | High-Level Timeline

March 2022	April	May	June	July	August	September - November 30th	December

7/1/2022 GO-LIVE

Choose or Stay Put: 3/1/2022 – 11/30/2022
Current members can select a next generation plan or will stay with their current plan. Previous members returning within 90 days will be returned to their prior plan.
Decide/Start Services: [3/1 – 6/11 ➡ 7/1] [6/12-7/31 ➡ 8/1] [8/1-11/30 ➡ Following Month]

Fee-For-Service (FFS) Pool: 3/1/2022 – 6/30/2022
Members newly eligible or returning to Medicaid with a gap of 90+ days or newly eligible for managed care will receive services through FFS.*
Assignment: Family continuity; Continuity of Care Providers.

Voluntary Choice Through Open Enrollment: 7/1/2022 – 11/30/2022
ALL members can change plans from 7/1/22 to 11/30/22.
Open Enrollment: November 2022

12/1/2022

Assessment with Possible Transfers

MCO Weighted Assignments: 18-month Transition

Additional Details

MCO Weighted Assignments: 18-month Transition

Assignment allocations are adjusted by region and by new/continuing plan status.

- 3/1/2022 – 6/30/2022: 100% to new/hybrid MCOs (FFS Pool)
- 7/1/2022 – 12/31/2022: New/Hybrid plans receive the majority. Continuing plans may receive a combined 16% of assignments.
- 1/1/2023 – 6/30/2023: New/Hybrid plans receive the majority. Continuing plans may receive a combined 24% of assignments.
- 7/1/2023 – 12/31/2023: New/Hybrid plans receive the majority. Continuing plans may receive a combined 40% of assignments.

December 2022 Assessment

- ***Excluded:*** Any member who has made a choice; Members w/ heightened needs.
- Notice of transfer to members 12/2/2022.
- Once notified, member can decline transfer 60 days before effective date of 2/1/2023; has additional 90 days to choose to go back.
- Transfer based on continuity of care providers.

Member Actions

2022 Member Transition & Enrollment

Beginning March 1, 2022, members can choose a next generation managed care plan by:

Visiting the Ohio Medicaid Consumer Hotline Portal at https://members.ohiomh.com

Contacting the Ohio Medicaid Consumer Hotline at (800) 324-8680

Communication to Ohio Medicaid Members

Phased Messaging Approach for Member Transition & Enrollment

The focus of messaging will evolve to address stakeholder needs at each point in time

	Plan *May – Nov. 2021*	**Educate** *Dec. 2021 – Feb. 2022*	**Enroll** *March – June 2022*	**Transition** *July – November 2022*
Objective	*Identify key messages and develop a communications and engagement strategy and plan*	*Educate all stakeholders on the member transition and enrollment process, timeline and steps managed care members must take to enroll in a next generation managed care plan*	*Support Medicaid managed care members in choosing the best next generation managed care plan for their healthcare needs*	*Communicate to Medicaid managed care members about their options to switch plans during the member voluntary optional change period*
	Identify Key Messages **Develop Strategy & Plan**	**Communicate Member Enrollment Process, Timeline & Activities** **Encourage Updating Contact Information**	**Empower Member Choice**	**Communicate Assigned Plans** **Communicate Process to Change Plans**
Stakeholder Groups	**Ohio Medicaid Members** **ODM Staff**	**Sister Agency Staff** **Elected Officials & Staff**	**MCEs** **Provider Associations**	**Providers** **Advocacy & Community Organizations**

Communication Channels Utilized for Members

ODM 2022 Member Transition & Enrollment

- ODM 2022 Periodical Newsletters
- FAQs / One Pagers
- Managed Care Plan Comparison
- @OhioMedicaid Twitter
- Member Enrollment Letter Mailing
- Member CallFire Campaign
- Ohio Medicaid YouTube Videos
- Website Messaging

Unwinding
COVID-19 Public Health Emergency (PHE) Declaration

Federal Public Health Emergency: Federal and State Guidance

Federal guidance

- HHS will provide states with 60 days' notice prior to the end of the PHE
- States must develop and document strategies to meet CMS timelines via the Post-COVID Eligibility and Enrollment Operational Plan including risk-based analysis ("risk-based analysis" is to identify individuals who are likely ineligible and prioritize processing of these cases)
- States may take up to twelve months following the end of the PHE to complete all eligibility and enrollment actions, redeterminations, renewals, pending applications

Federal reconciliation bill requirements (Build Back Better Act)

- If passed*, key provisions include:
  - Phase out of the 6.2 percentage point FMAP enhancement over two quarters and sunset of continuous enrollment requirement on October 1, 2022
  - States may begin disenrolling ineligible individuals beginning April 1, 2022, if those individuals had 12 months of continuous enrollment and the State meets certain requirements

HB110 requirements

- ODM must complete eligibility renewals and redeterminations within 90 days after the end of the PHE
- Within 60 days of the end of the PHE, ODM must complete and act on eligibility redeterminations for all beneficiaries who haven't had a redetermination in the previous 12 months
- ODM must seek approval from CMS to conduct redeterminations for all beneficiaries who were enrolled for 3+ months during the PHE
- ODM must employ a vendor to use 3rd party data sources to "identify individuals who are likely ineligible"
  - ODM will use this to satisfy in part the CMS expectation for a "risk-based approach"

**The future of BBB is uncertain at this time*

PHE: Timeframes & Implications for Member Churn

- States have been told there will be (at least) a 60-day notice given prior to expiration
- ODM will start eligibility unwinding activities 60 days before the PHE expiration date
- Current PHE was renewed on 1/6/22. Subsequent 90-day PHE renewal dates are:

PHE Expiration or Renewal Dates	60 Day Notice of Non-Renewal of PHE & ODM Start Unwinding
~~4/16/22~~	No notice provided -2/15/22
7/15/22	5/16/22
10/13/22	8/14/22
1/11/2023	11/12/22

Most likely

- Resource slides at the end of this presentation provide more detail

Public Health Emergency Ending: Update on Unwinding Plan

Restart eligibility and enrollment activities

- ODM will leverage the passive renewal process to renew as many past due cases as possible prior to the end of the PHE
- ODM is also evaluating approaches to resuming eligibility and enrollment activities once the PHE ends

Encourage members to update their contact information and work with plans to coordinate outreach methods for increasing renewal packet response rates

Plan and processes being finalized now for ODM and stakeholders to **work together**

- Temporary authorities adopted by states to respond to the PHE are scheduled to automatically sunset upon termination of the PHE or another specified date
  - Examine all 1135 and Appendix K provisions to determine which to keep after the PHE ends

We know that any confusion or questions causes people to ask their providers for guidance or call the counties. We need your help.

→ ODM is committed to working with stakeholder associations to keep them appraised and get their input

Interactive Discussion

Member Transition & Enrollment

Discussion Questions

1. What are ways for Ohio Medicaid managed care members to **receive information** regarding the next generation program and actions required by them?

2. What **questions are you receiving** from members about the next generation Ohio Medicaid program?

3. How can we **ensure your organization** has the information and resources needed to assist members?

What’s Next?

Member Transition & Enrollment

How You Can Help

We appreciate your ongoing support of the next generation of Ohio Medicaid! There are additional ways you can consider helping with member transition and enrollment.

Join us for **future touchpoints** and presentations

Share information from the **partner packet** with members

Send questions that you have or are hearing in the community to ODMNextGen@medicaid.ohio.gov

Encourage members to **update their contact information**

Ohio Medicaid Member Contact Information Update

Member Transition & Enrollment

The most important action for Ohio Medicaid members right now is to update their contact information to make sure they do not miss any information about the next generation of Ohio Medicaid

Members Have Three Options to Update Their Contact Information

Call (844) 640-6446. After selecting the option for their preferred language, they should select option 2 and will be prompted to enter their zip code

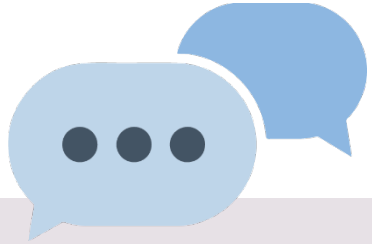
Individuals with an existing Self-Service Portal (SSP) account can **report changes online at https://ssp.benefits.ohio.gov**. After logging in, they should click the Access my Benefits tile, then click Report a Change to my Case from the drop down and follow the prompts

Contact their County Department of Job and Family Services (CDJFS). Ohio Medicaid members can find their CDJFS by viewing the County Directory at https://jfs.ohio.gov/County/County_Directory.stm

Contact Information Includes:

- Name
- Residential Address
- Mailing Address (if different than residential address)
- Phone Number (cell and landline, if applicable)
- Email Address

Thank you for coming!



We appreciate all your time and input today! If you have any questions, please feel free to reach us via email.

Managed Care Procurement: ODMNextGen@medicaid.ohio.gov

OhioRISE: OhioRISE@medicaid.ohio.gov

SPBM / PPAC: MedicaidSPBM@medicaid.ohio.gov

Fiscal Intermediary: ODMFiscalIntermediary@medicaid.ohio.gov

PNM: PNMCommunications@medicaid.ohio.gov

Centralized Credentialing: Credentialing@medicaid.ohio.gov