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Most Recent Long Term Care Information

(Our Main Focus is on Health Care Delivery in Ohio and PASRR/LOC related Items)

9/18/14- Part of the Balancing Incentive Program (BIP) requires states to develop a standardized assessment instrument that would determine an individual's eligibility for services, comprehensively assess their physical, psychological and behavioral health needs, and help formulate a care plan. As a result, a tool that has been named the Adult Comprehensive Assessment Tool (ACAT) has been developed. The next stage of the development process is testing the draft tool for inter-rater reliability, face validity and maintenance of eligibility. This will occur in two phases. The first phase of testing concerns inter-rater reliability and face validity. In this phase, the Area Agencies on Aging (AAA), in conjunction with ODM (Ohio Department of Medicaid), will be reaching out to a small number of nursing facility residents who have been randomly selected to participate in the testing stage. NF-based waiver recipients will also be included in the testing and assisted living waiver facilities will be part of the total waiver sample. Residents who participate, their guardian (if applicable), and nursing facility administrators will be sent a letter from ODM that describes the details of the testing process. It is important to note that participation in the testing process in no way affects current eligibility for Medicaid programs. The actual assessment process will include two staff members from the AAA who will each complete an assessment, and then both will submit their results to ODM for evaluation. As a result of testing, changes to the draft assessment tool may be made. Training of assessors for the first phase of testing will be on September 30 and October 2. Assessors will then have eight weeks to complete their assignments which will be due by Wednesday, November 26, 2014. Phase 2 testing will begin following the evaluation of Phase 1 results. Phase 2 will include a much larger sample of NF residents and waiver recipients, and will compare eligibility results that have been determined under both the old and new tools. Information regarding the details of Phase 2 testing will be provided closer to the anticipated start date in January 2015.

9/5/14- **WRAAA goes to the Beach for its new CEO-**

E. Douglas Beach was recently announced as the new CEO for the Cleveland Western Reserve Area Agency on Aging. He will start October 13, 2014. Secretary E. Douglas Beach was appointed by Governor Charlie Crist on February 13, 2007 as the Secretary of the Florida Department of Elder Affairs. One of the most important goals for the department is to promote and advocate services for the state's elderly population. For more information on Dr. Beach, go to

http://www.n4a.org/files/programs/ncst/secretarybio.pdf. With Dr. Beach's experience, this appears to be a great hire.

8/20/14- Some My Care Ohio Transportation news has recently become available. Nursing facilities should schedule transportation with their company of choice. The ambulance company will obtain a pre-authorization from the plan. Access to Care handles this for Buckeye Community Health Plans. The ambulance company bills the plan and the plan pays them. At this time, United Health Care still requires scheduling through MTM but they are planning alternatives in the near future. CareSource has provide a guide for transportation. You can view it at http://www.ohca.org/docs/documents/101/CareSource_transportation_quick_reference_guide.pdf . One extremely difficult aspect regarding My Care Ohio Transportation is that none of the plans pick up the cost for NF to NF transfers. Traditional Medicaid typically covers this cost. Now either one of the NF's will have to cover the cost, pass it on to a family member or have other form of transportation available for the transfer.

LTCO was informed that the Area Agency on Aging in Cleveland is offering incentives for the MyCare/CareSource program. The Agency management has created several temporary incentives to help with recruitment and retention of this position. The incentives listed below became effective on Monday, August 18, 2014 and will continue as needed:

Any employee who refers a licensed clinical candidate for employment at WRAAA will receive a $1,500 bonus if the candidate is hired and stays with the Agency for a full six (6) months;

- Newly hired licensed clinical staff who start their employment in the MyCare/CareSource program will receive a $5,000 bonus if they stay in the program for a full six months;
- Existing licensed clinical staff currently working in the MyCare/CareSource program will receive a $5,000 bonus if they stay with the program at WRAAA for the next six months. Employees who leave the program or the Agency during the six month period will not be eligible for the bonus.
- Current employees who are licensed clinical professionals and are working in other programs at WRAAA will be allowed to transfer to the MyCare/CareSource program and upon transfer will become eligible for the $5,000 bonus if they stay in their new position for six months. Current employees will need to interview with the MyCare/CareSource director to determine if they will be eligible for this transition. If a current employee makes this transition, they will not be eligible to transfer to another department for one calendar year.

  This incentive has caused more rift among staff as the incentives are only directed toward one area of the agency and not others where staff continue to work extremely hard but are not rewarded. We have been informed that this is not the

first time that this agency has awarded one department and caused derision in the workplace by not providing incentives and bonuses to other departments.

LTCO has learned that a new level of care assessment (LOC) tool for adults is moving closer to becoming implemented. This tool will go through two different tests with folks from the both the Area Agency on Aging and Medicaid certified nursing facilities doing the assessments. The first will be for inter-rater reliability and face validity. This ensures the tool is capturing the information needed in a consistent fashion with results similar to the current assessment. The second test is for maintenance of eligibility. This is to ensure that the tool does not impact the eligibility of individuals. The plan for the first test is to have face to face assessments with 40 SNF and 40 waiver recipients.

Each assessment will have two people from the Area Agencies on Aging; one using the 3697 and one using the new assessment. The assessors will go through a two-day training session in September on the new tool. The second part will have a larger sample and will involve SNF staff. The LOC assessment will be done as it is today with both the new and old tool. ODM has asked the SNF provider associations to provide volunteer facilities to participate In the study. The SNF staff will most likely have to take a similar two day training course on the new assessment tool. More information, including how to volunteer, will be available once the sampling method and time line for the second test is established.

7/15/2014-Over 100,000 elderly and disabled people are now covered under the My Care Ohio program. Over 18,000 receiving both Medicaid and Medicare benefits from their plan. The final regions, EC (Portage, Stark, Summit and Wayne), C (Delaware, Franklin, Madison, Pickaway, Union) and WC (Clark, Greene, Montgomery), recently started. The program is schedule to go until the end of 2017. A decision will be made to either continue the program, expand the program, or discontinue the program as that time approaches.

On a sad note, in part due to the My Care Ohio program, the Cleveland Area Agency on Aging appears to be struggling. Over the last several months, morale of the employees that we have spoken to has been very low. Just over the past month, several workers have handed in their resignations due to a report of difficult working conditions. Many of the workers were long term employees of the agency. In addition, many current employees that we have had conversations with are afraid of unjustly losing their jobs. This is something that needs to be corrected. This agency has had the reputation of providing excellent service to many frail elderly over the past twenty five years. For the benefit of us all, we need this agency to somehow turn itself around and regain its past glory. Its current CEO will retire sometime this year and it is our hope that the search for a new CEO will inject some new life into the agency and turn things around.

Information Regarding Aetna and Molina for My Care Ohio

Aetna: Prior authorization (PA) for custodial residents -
Aetna will be loading the PAs in based on data from Medicaid. The provider will not need to obtain PAs to bill for those residents. A new PA will be required if a "Medicaid Only" member changes from Medicare to Medicaid. Prior authorizations - PAs will be needed for new SNF stays and should be obtained from utilization management (UM) by calling 855-364-0974 or fax 855-734-9398.
While providers can go through care management
for the PA, the care manager will only act as a conduit of information to UM. Bad debt-Aetna will be making an adjustment to rates for Medicare bad debt via a contract amendment.
Patient liability -Aetna will use the monthly 834 data for PL amounts. Providers should therefore use the PL calculated in the system at the start of the month. Any change in PL during the month should be filed as an adjustment claim with the 9401 as documentation. Admission date on claims-Use the date the person was actually admitted into the facility. Non-clearing house bill submission-Use portal for individual claims submission. Currently working on developing a process for "batching" claims.
Billing questions/issues
- Aetna will have multiple "provider liaisons" that will be assigned to facilities that can handle billing and other provider related issues.
Care management -Care managers will be assigned to a facility. Medicare denials -Will not need one immediately; however, current policy is to follow standard COB practices and require billing Medicare first for denial. (We are still working with them on that issue. Molina: Prior authorization for custodial residents -Molina will be following a similar process and will be loading the PAs based on data from Medicaid. Providers will not need to obtain PAs to bill for those residents. A new PA will be required if a "Medicaid Only" member changes from Medicare to Medicaid.
Prior authorizations -PAs will be needed for new SNF stays and should be obtained from utilization management (UM) by calling 855-322-4079 or fax 866-449-6843.
Patient liability -Molina will also use the monthly 834 data for PL amounts. Providers should therefore use the PL calculated in the system at the start of the month. Any change in PL during the month should be filed as an adjustment claim with the 9401 as documentation. If the PL in Molina's system does not match the claim, then the provider should file a claim reconsideration (resubmission). Non-clearing house bill submission-Use portal for individual claims submission. Will need to use Emdeon "WebConnect" for batch submission. Please contact Daniel Vickers for more information
(Daniel.Vickers@molinahealthcare.com 888-562-5442 ext 212575).
Care management -Each facility will have one care manager assigned to it. The care managers are divided into regions.

6/14/14- My Care Ohio Frequently Asked Questions-
http://www.rcxbilling.com/pdf/Mycare_Ohio_FAQs_final_v2.pdf

MyCare Ohio: Prior authorizations (PA) and having the information necessary to bill remain a focus. Below is a summary for each plan in the NE region of what we know about and what we are doing to try and make sure your May claims go through.
Buckeye: Buckeye is still in the process of assigning PAs to the long term care non-skilled population. They anticipate having those finished and out to providers via an excel spreadsheet in June. We are working with Buckeye on expediting the process and will update you as we learn more. The PAs will be necessary for claims submission. The authorization span will be for one year. A different PA is needed for bed hold days and a request should be submitted when the person goes to the hospital.

CareSource: For the long-term care non-skilled residents that are enrolled in MyCare for the May 1 effective date, providers can use the member ID # in the prior authorization field. This number can be used as long as the person remains in the facility until an assessment has been done and a PA is issued. So far, it is unclear if a claim has gone through with a Member ID. We are working with CareSource on this. CareSource is currently in the process of issuing the PAs and assigning care managers. If the person leaves the facility and returns skilled, a new PA will be needed for the skilled service, but not for the non-skilled service. A different PA is not needed for bed hold days.

UnitedHealthcare: UHC continues to point providers to their web portal (www.uhconline.com) or the LTC intake coordinator number (877-285-9093) ***to request PAs.*** We have heard of difficulties using the portal and currently recommend calling the number and requesting a six month authorization. We have asked UHC to consider allowing providers that are requesting PAs for a large number of residents to submit a spreadsheet. Sources tell us that some LTC intake coordinators are using that approach. UHC has told The Academy that the provider should receive a call from the case manager with the approval and authorization span within 72 hours. The PA will be valid back to 5/1, but we are hearing that some authorizations are for as short as 30 days. Providers will have to track the PA spans and ensure another request is made before the span expires. A different PA is needed for bed hold days. ***UHC has said that the PAs will NOT be necessary for claims submission; however, we are not confident that a claim will process without the PA.*** We are working on sorting through this with UHC and are still recommending you call the 877 number and request PAs.

Prior authorizations are going to be required for most services and changes in payer. (Example: When a traditional Medicare service switches to a MyCare Ohio Medicaid covered service.) The plans have resources available, such as the quick reference guides, for the services that require a PA. You can find links to these and other resources on The Academy's MyCare website.

It is important that you let The Academy know when you run into bumps in the road as soon as possible so we can work on getting them fixed. ***Please continue to*** *let us know your concerns as we move forward.* We'll work on getting them fixed as soon as

possible.

MBR update: Medicaid QMs, PASRR, CON and more — The Senate passed H.B. 483, the Mid-biennial budget review bill, with several changes related to long-term care. Below is a summary of pertinent changes:

- Replaces the advance directive and no over head paging Medicaid reimbursement quality measures with two new measure: medication administration without the use of a medication cart and the employment of a full time social worker;
- Revises the PASRR rules to allow the director of mental health and addiction services to issue a license to a facility, that meets certain conditions, that allows the facility to perform a different screening and resident review process;
- Allows for a certificate of need (CON) replacement if the reviewable activity that the original CON was granted needs to be implemented in a manner that is not in substantial accordance with the approved certificate of need;
- Creates the "Nursing Facility Behavioral Health Advisory Workgroup" to develop recommendations for a pilot project to designate not more than 1,000 in discrete units of nursing facilities to serve individuals with behavioral health needs;
- Moves the alternative payment method (enhanced rate) section for high-need Medicaid recipients that would otherwise receive services in a long-term acute care hospital from temporary law to permanent law. Better defines the requirements for the method including the ability to require a prior authorization for services in a LTAC or rehabilitation hospital;
- Removes the assisted living waiver rate increases;
- Removes the 90 day cost report requirement for new nursing facilities.

The bill now heads to conference committee. It is expected to be voted on by the end of next week. Please contact The Academy for more information on HB 483.

MyCare Ohio: UHC and Aetna training — UnitedHealthcare has added more webinars for providers participating in MyCare Ohio. Please download the PDF for more information.

5/30/14- We have gone through one month of My Care Ohio in seven regions of Ohio.

For review;

What is MyCare Ohio?

MyCare Ohio is Ohio's Integrated Care Delivery System (ICDS) - a system of managed care plans designed to coordinate physical, behavioral, and long-term care services for individuals over the age of 18 who are eligible for **both** Medicaid and Medicare. This includes people with disabilities, older adults and individuals who receive behavioral

health services. The program is administered by the Ohio Department of Medicaid (ODM).

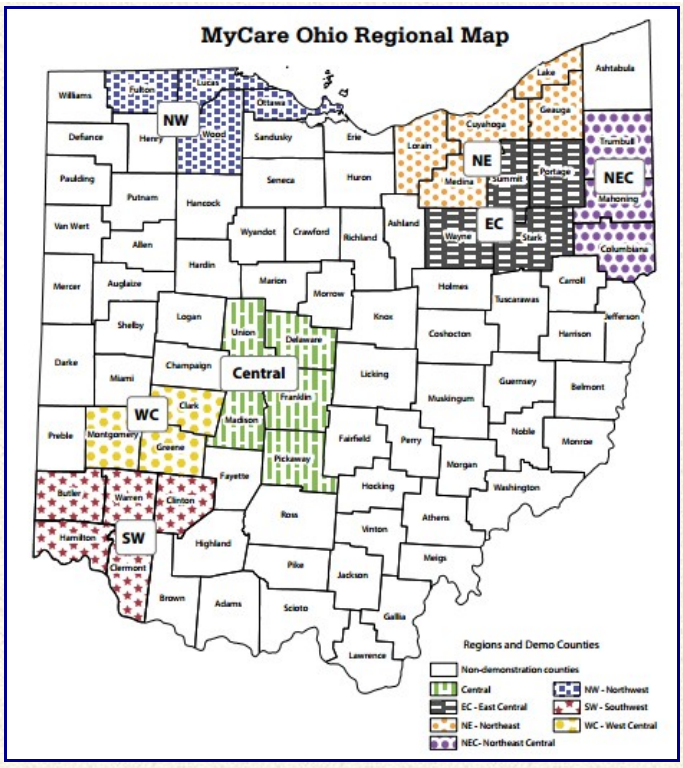
What does Ohio hope to achieve through MyCare Ohio?

The population served by MyCare Ohio includes some of the most vulnerable Ohioans: low-income, severely disabled adults with a track record of bouncing in and out of emergency rooms and hospitals, experiencing poor care and bad outcomes. Additionally, costs to provide care to these individuals is typically much higher than care provided to other beneficiaries, with no one entity accountable for the care of the whole person.

By better coordinating the benefits offered through the Medicaid and Medicare programs, the MyCare Ohio program aims to improve the overall health and well-being of these individuals while also improving health care quality and outcomes, as well as containing costs.

- **Single Point of Contact:** The MyCare Ohio managed care plans will be a single point of contact for all individuals enrolled in both Medicare and Medicaid. This will allow individuals to easily navigate their health care goals and needs across various services and health care settings.
- **Person-Centered Care:** The plans will encourage choice and self-direction; provide support for individuals to remain independent and in the community; and provide care management that includes face-to-face visits in the home and community.

Statewide, MyCare Ohio is available in seven regions (see map) covering 29 counties and approximately 114,000 individuals.



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

From the individuals that we have interviewed throughout the state, it has been a horrible experience thus far. The integration between the HMO's and the Area Agency on Aging (AAA's) has not gone well. The AAA's have had extensive experience with the waiver programs and the HMO's have not. As indicated above, the goal is to improve the overall health and well-being of these individuals while also improving health care quality and outcomes, as well as containing costs. Thus far, it has been a nightmare. We hope it improves but it appears that it is going to take a long time to get this straight. One example is the Assisted Living Waiver. Prior to 5/1/14 an individual looking to apply for the Assisted Living waiver merely had to contact the AAA for an assessment. However, this is not the case after 5/1/14 for someone on My Care Ohio. Even the supervisors that we interviewed at the AAA do not know the current process to apply for the AL waiver for someone on My Care Ohio. We have got to get this straight as the only people suffering are the consumers.

5/17/14- It is the third week into the MyCare Ohio demonstration program and multiple concerns permeate throughout. You would think that with all the so called preparation that was put into this demonstration that these issues would have been resolved prior to implementation. However, prior authorizations (PA) are the major concern for providers as the health plans in the NE region attempt to register all of their participants. Denials for claims are an issue along with delays and interruptions in waiver services and general disarray with regard to what roles the Area Agencies on Aging play and how they blend in with My Care Ohio to provide services along side or in conjunction with the HMO's.

If a person is a My Care Ohio participant, the HMO has to assess the individual before the waiver service can begin. This has been especially aggravating for individuals who have not been enrolled as yet in the Medicaid portion of the My Care Ohio plan. For instance, there are many individuals who are technically My Care Ohio Participants but the Medicaid portion does not begin until 6/1/14. The Area Agency will not assess them and the since the enrollment date is not until 6/1/14 the HMO has not assigned a care manager to the person as yet so they are not assessing either. The individual is in limbo. This makes it difficult for the individuals who are in the community waiting for services and discharge planners in hospitals and nursing facilities as they do not know who to refer to for services or who will follow up with the person if they are discharged to home.

Some Q&A on Levels of Care (LOC)

1) Do we need a LOC on All My Care Ohio patients coming into Medicaid certified nursing facilities? If not, which patients do we need them on?

Yes (The main point you have to think of is if an individual is not a My Care Ohio participant you need to follow the current process for obtaining a LOC from the Area Agency on Aging (AAA). A LOC is still needed for everyone who transitions to Medicaid and will be done by the AAA (just as it is now) as people convert from Medicare to Medicaid. However, LOC's will be done by the HMO plans when a dual benefit member (signed up for My Care for both Medicaid and Medicare benefits) enters a nursing facility for skilled care and would need to move to Medicaid once their skilled benefits exhaust. In that scenario, we will be requesting the level of care from the plans and not the Area Agency on Aging. At this point, we know the plans are required to follow the same LOC criteria that exists today for meeting NF-based services (need for 24 hours supervision to prevent harm; or 1 ADL plus med admin; or 2 ADLs) but we are unsure if they must use the same 3697 form. My guess is they will not have to or an equal form .

With respect to the LOC and Prior Authorization (Or Pre Cert, whatever you want to call it), the LOC is different from Prior Authorization except in the case as noted above where obtaining the LOC from the plan is also obtaining prior authorization for the Medicaid long term care services. Please remember that many (At least those individuals who are admitted to the NF under Medicaid payment) will get a LOC before they are even enrolled into the MyCare program because the person needs to be a full dual (eligible for full Medicaid benefits) and to become a full dual living in a nursing facility, that person would have needed to have a LOC completed by the AAA. Once a beneficiary becomes a full dual, then they will be enrolled into MyCare and the 60 day enrollment process will begin. Once they get enrolled in the plan, the LOC will have already have been issued BUT you may need to obtain an authorization

from the plan (which could include an authorization number) for them to pay for Medicaid services in the nursing facility.

2) What do we do on weekend admissions for:
Long Term Care patients returning from the hospital to the nursing facility? Do we need LOC? Do we need Pre-Cert? (if so, how do we get on weekend?)

You do not need a LOC unless the person is out of bed hold days and not a My Care participant but you may need an authorization from the HMO plan if the person is a My Care Ohio participant. It would really be based on what services they are returning to? If this is a new skilled service, yes you would need to obtain a prior authorization. However, what if this a continuation of Medicaid coming back to a bed hold? If so, the Medicaid 6 month (UHC) or year-long (Buckeye) authorization may be fine. At this point, I would work with each individual plan and get at their individual processes.

3) On new admissions on weekends...do we need LOC? If so, how can we get it?

To answer this you need to think through the actual situation and if the person is a My Care Participant or not. For individuals who are not My Care then the LOC is absolutely needed if the payment source is Medicaid. However, if the person is a My Care Ohio participant an authorization is definitely needed.

Prior authorizations are a huge nightmare also. Many providers are not sure what provide authorizations are required or if they will be denied payment for services. Below is a summary for each plan in the NE region of what is currently known about Prior Authorizations or Pre-Certifications today.

Buckeye: Buckeye is in the process of assigning PAs to the long term care non-skilled population. They anticipate having those finished and out to providers via an excel spreadsheet by May 28. ***The PAs will be necessary for claims submission.*** The authorization span will be for one year.

CareSource: For the long-term care non-skilled residents that are enrolled in MyCare for the May 1 effective date, providers can use the member ID # in the prior authorization field. This number can be used as long as the person remains in the facility until an assessment has been done and a PA is issued. If the person leaves the facility and returns skilled, a new PA will be needed. A different PA is not needed for bed hold days.

UnitedHealthcare: UHC continues to point providers to their web portal (www.uhconline.com) or the 1-800 number to determine PAs. As of right now, we are waiting to find out how many of those PAs are available and UHC's approach to ensure providers have the information they need to file claims. ***The PAs will be necessary for claims submission.***

Prior authorizations are going to be required for most services and changes in payer. (Example: When a traditional Medicare service switches to a MyCare Ohio Mediciad covered service.) The plans have resources available, such as the quick reference guides, for the services that require a PA. Information is available at http://www.seniorhealthsciences.org/mycareohio.shtml

MyCare Ohio: ODM provides some clarity on hospice — Hospice is one of the unique benefits in the MyCare Ohio program because the Medicare benefit is carved-out of the program, but any Medicaid room and board is not. This has raised some questions around prior authorizations and continuation of services. The Ohio Department of Medicaid (ODM) sent an email this week outlining their policies related to hospice:

"In response to multiple inquiries regarding the Medicaid room and board payment for services received in a nursing home during a Medicare hospice stay:
The Medicaid transition requirement for people residing in nursing facilities on the effective date of MyCare Ohio enrollment includes those who are using Medicare hospice services, for whom Medicaid is paying the room and board amount. The FFS Medicaid room and board rate applies for non-contracted facilities.
For individuals who want to enroll in hospice services after the effective date of MyCare Ohio enrollment, plans may require prior authorization for the room and board component.
Patient Liability must be deducted from the room and board amount in circumstances both when the hospice is billing T2046 or the NF is billing the MyCare Ohio plan directly for the room and board payment."

MyCare Ohio: Training schedules updated — Both Molina and Buckeye have added additional webinars for MyCare Ohio training. Molina has added June webinars in addition to their May dates. Buckeye has scheduled three webinars starting next week:

Wednesday, May 21	4:30 PM — 5:30 PM
Wednesday, May 28	10:00 AM — 11:00 AM
Thursday, May 29	12:00 PM — 1:00 PM

Buckeye is asking providers to RSVP to lmattox@centene.com. To facilitate registration, please add date selected in subject line. Example: May 21 Webinar. This will assist Buckeye in providing you the meeting details and a copy of the presentation. The Academy continues to update our MyCare website with the latest information including training opportunities.

5/2/14- **MyCare Ohio has begun in Northeast Ohio –** The MyCare Ohio demonstration program began on 5/1/14 the NE region of Ohio. About 27,000 people in Lorain, Medina, Cuyahoga, Geauga, and Lake counties are now receiving MyCare benefits, with about 5,000 receiving both Medicaid and Medicare services.

There are three plans serving the NE region: CareSource, Buckeye, and United Healthcare. MyCare participants can be either fully enrolled for Medicaid and Medicare benefits under the same plan or only receive Medicaid benefits. Members should be receiving their cards in the mail, if they have not received them already. Each member will receive his or her card in the mail separately. The MITS portal will have enrollment information now that it is past the effective date of May 1. Any remaining enrollment issues should be directed to the Medicaid hotline. O*nly eligible people 60 days prior to May 1 will be enrolled as of May 1.* Enrollment is an ongoing process and newly eligibly people have at least 60 days to select a plan.

The plans should have the information necessary to pre-load the prior authorizations (PA) such as level of care determinations. The initial PA should be done based on data sent to the plans by Medicaid for those in a facility at the time of the effective date of enrollment. However, PA some plans may require a PA number on the claim. Buckeye has already confirmed that they will require PA numbers on their claims. Discussions are currently going on with Buckeye on developing a method to facilitate the acquisition of the PA numbers or an alternative method for payment. For CareSource, providers can use the Member ID # as the PA #. We are still waiting on UHC and will let you know their process as soon as we can.

MyCare training update; Buckeye co-insurance policy — The MyCare plans have been providing training to MyCare providers. Many of these resources are available on their websites:

UnitedHealthcare - Training slides; key contact information; provider manual.
CareSource - Claims training; provider manual (key contacts on PDF pages 2 and 3)
Buckeye - Training slides; provider manual

Buckeye noted in their training materials that they will have a process of adjusting claims for Medicare days 21-100 for bad debt, similar to what Medicare is doing today. This would only apply to full benefit members (those receiving both Medicaid and Medicare services). "Medicaid only" members would still be receiving Medicare benefits as they did prior to MyCare. For Medicaid only MyCare residents, the providers will have to bill the MyCare Medicaid plans for any coinsurance amounts as secondary

payer (instead of Medicaid). The plans will treat those claims using the same process as Medicaid.

Frequently asked questions on My Care Ohio can be seen at the release our MyCare FAQ. The information in the document has been collected from a variety of sources, including Medicaid, the health plans, and other associations. As always, it is subject to change. Medicaid has also released the final version of the MyCare plan transition and payment requirements. It outlines the plans responsibilities for the different MyCare services and their members' transition into the demonstration program.

4/20/14- MyCare Ohio: Latest info before NE start – The MyCare Ohio demonstration program is set to start May in the NE region.
Training: The plans for that region (CareSource, Buckeye, and United Healthcare) have started training for providers. Buckeye just released information regarding its SNF specific training webinars: Wednesday, April 30, 3 – 4:00 PM; Thursday, May 1, 1 – 2:00 PM; Friday, May 2, 9 – 10:00 AM. SNF providers can contact Leetha Mattox at lmattox@centene.com or 866-246-4356 ext. 24222 to register for the webinars. Registration is required. More information on additional MyCare Ohio training can be found on our MyCare Ohio webpage.
Prior Authorization (PA): The plans will use the current LOC information provided by the state for the initial prior authorization (PA) as the MyCare program is rolled out or a resident is initially enrolled in the program while in the facility. The plans will need admission information (not provided by state) to determine the person's length of stay in a facility. Care managers will issue the PA for individuals already enrolled in MyCare and admitted from the community or hospital. Most of the plans are requiring a PA for bed hold days (CareSource has indicated they will not and it will be approved with any hospital stay); however, because of the care management process the plans do not see there being any problems issuing the PA, especially for hospitalizations. Prior authorizations are not required for emergency situations per federal regulations; however, plans ask that providers use their best clinical judgment when determining if the person's care manager can be contacted prior to sending the person to the emergency room. Care managers should be contacted as soon as possible if a person is sent to the ER. For ancillary services, the plans will accept a PA issued prior to enrollment and also allow the beneficiary to continue to receive services from their current provider during the transition period. The beneficiary will eventually have to switch to a contracted provider. The Ohio Department of Medicaid has created a ***draft*** document outlining the payment requirements for plans during the transition period.
Billing/Claims: The plans have all indicated that they will be ready to receive claims. They have been testing, or will be testing, claims with several providers. While the plans will have their systems ready, SNF providers are advised to bill monthly. The plans have said that claims will not be denied because of difference in patient liability. Currently, there is no automatic crossover for Medicare coinsurance for "Medicaid only"

beneficiaries. The providers will have to bill the plans for any coinsurance.
Hospice and Ancillary Services: The plans have confirmed each respective billing process for the Medicaid share of hospice services. UHC and Aetna will have the facility bill them directly. Molina, Buckeye, and CareSource will be contracting with the Hospice providers. Ancillary service providers that are providing services not covered under the per diem (DME, lab, transportation, etc...) will have to contract with the plans.

SCRIPPS biennial and AGE family survey info headed SNFs way — It is survey time for LTC providers. Skilled nursing facilities and residential care facilities should have received information on The Biennial Survey of Long-Term Care Facilities being conducted by the Scripps Gerontology Center at Miami University. The survey has been streamlined in an effort to make it easier for providers to complete and is done online. The date to complete the mandatory survey is May 27, 2014. Meanwhile, the Department of Aging will begin the Family Satisfaction Survey process next week. The Department will be staggering the mailing of the materials based on zip code. The information will be sent in a #10 envelope addressed to "The Administrator." More information, including the timeline for the mailings, is available in the introductory letter.

4/12/14-House moves MBR bills before spring break — The Ohio House of Representatives moved several bills this week prior to their spring break. One of the bills, H.B. 483, is the Mid-biennial Budget Review bill that addresses appropriations. The MBR has limited language that impacts skilled nursing facilities despite an omnibus amendment that want through committee earlier in the week. One section of the bill would require SNFs to notify residents and their guardians or sponsors if a sex offender was admitted to the facility. The Academy opposes the language as written, and is working on changes that remove the notification while ensuring the health and safety of the residents. Another section of the bill makes changes to the CON regulations that would allow an RCF to convert 20 beds to SNF beds using licenses from a neighboring county. It is believed the language is directed at Madison county. The bill heads to the Senate where it is expected to move rather quickly after the break.
MyCare Ohio: Hospice and bed hold PAs — The MyCare Ohio demonstration project is less than three weeks away from going live in the NE region. The latest news centered around the Medicaid room and board rate for hospice services, currently paid to the SNFs from hospice providers. The Academy had noted in past Weekly articles and other updates that the MyCare managed care plans would allow the SNFs to bill for the hospice service. The Academy learned earlier this week that Buckeye will not allow SNFs to bill for the Medicaid room and board, but the hospice company will bill Buckeye directly. Molina has said it would do the same because hospice is not in their SNF contracts; however, Molina may amend the contracts in the future to allow for SNF billing. UHC has the opposite situation; the hospice benefit is in the SNF contract, but

they do not have contracts with hospice providers. They expect the SNF to bill them for the Medicaid room and board. Aetna and CareSource have not confirmed what their billing process with be for hospice Medicaid room and board. On a similar note, the plans have different approaches for prior authorization of bed hold days. All of the plans will be paying at the discounted Medicaid rate based on occupancy. The difference is prior authorization (PA). UHC and Buckeye have said that they will need a PA for those bed holds, meaning that if it is for a hospitalization, two PAs would be needed (one for the bed hold and one for hospital visit). Molina and Aetna are unsure at the moment, while CareSource said the authorization is for the SNF service over that authorized time period, regardless if the person leaves the facility for a hospital stay. This means a new PA is not needed for the bed hold. All of the plans suggested that getting a PA should not be a problem since any change in condition that requires a hospitalization or if a therapeutic stay is in the care plan, the care manager should be aware and able to facility the PA.

MyCare Ohio: Loading providers and training updates — One of the concerns The Academy has heard the most from our members is prompt payment for MyCare Ohio services. One of the keys to getting paid timely is to be "loaded" into the system. According to the plans, they are currently working on loading the providers they have contracted with. If a provider has not been credentialed and does not have a final contract, some plans are "pre-loading" provider information based on available data, while other plans will load providers once the claims are received using claim data. For "non-par" providers, a single case agreement is necessary for payment purposes. The process can cause a delay in payment versus being a contracted provider. While it is too late for NE region providers to begin the credentialing process and finish by May 1, there may be some time in the other regions. If you have not contracted with the plans and wish to do so, please contact the plan as soon as possible to try and avoid any delays in payment. Even if you plan on not being a network provider, you may want to contact the plan and let them know so you can be loaded into the system as a non-par provider for the future MyCare Ohio beneficiaries currently in your building.
In other news, the managed care plans will be providing training to MyCare Ohio providers, including SNFs and/or long-term care services and supports providers. Most of the training for LTC will begin the week of April 23rd. The plans have yet to confirm dates and times for the training. Most of the training will be web based. The Academy will notify you once the dates are made available.

4/4/14-MyCare Ohio: 60 day enrollment period for June effective date regions started — Enrollment in the MyCare Ohio demonstration program expanded this week as Ohio Medicaid sent enrollment letters for the regions that have effective dates of June 1 (Northwest, Northeast Central, and Southwest). Beneficiaries will have 30 days to actively enroll before passive enrollment into the Medicaid benefit only begins. Please

note that only the beneficiary or full authorized representative can make plan and benefit selections. Individuals will have until May 26 to select or change a plan prior to the June 1 effective date. NE region beneficiaries have until April 25 to change their plan.
MyCare Ohio: You need to be "loaded" — Providers are reminded that they need to be "loaded" into each plan's payment system in order for claims and payment to process properly. This includes both providers with in-network contracts and "single case" contracts. If the provider has signed a MyCare Ohio contract with a plan, have gone through the credentialing, and received a "welcome letter" or other notification, that provider should be loaded into their system. If a provider choose to not join the plan's network, it will need to work with the plan to ensure it has the necessary "single case" contracts in place and are loaded into their system. If a provider uses a third-party for managing managed care claims or contracts, the provider should work with third-party for MyCare Ohio as they would for any other managed care product. If you want to check if a provider is loaded, you can contact the Medicaid Hotline (1-800-324-8680) and ask if the provider is listed as a network provider for the plan in question. Or you can contact the plan directly via the provider relations number or search the plan's online MyCare Ohio provider directory.

MyCare Ohio: Hospice and DME contracting — Hospice is a unique benefit in the MyCare Ohio program because the Medicare benefit is not covered under MyCare Ohio, but the Medicaid portion is. The result is that the Medicare benefit will remain as it does today for all enrollees in MyCare Ohio. The Medicaid payment will be the responsibility of the MyCare Ohio plan. The plans have informed The Academy that they do not intend to contract with hospice providers for MyCare Ohio hospice Medicaid benefits. The expectation is that SNF providers will bill the MyCare plans for the Medicaid benefit (room and board). This is because the plans believe there is no reason for them to contract with an entity that only acts as a pass through, especially if the plan already has a contract with the provider the funds are supposed to be paid. In contrast, durable medical equipment (DME) suppliers that provide services to residents not covered under the daily SNF per diem will have to contract with MyCare plans. There is a 90 day transition period for services authorized at initial enrollment. The plans have indicated they are willing to discuss contracting with DME providers that already have relationships with SNF residents.

3/29/14-MyCare Ohio NE beneficiaries passively enrolled — Enrollment in the MyCare Ohio demonstration program took a big step forward this week, with beneficiaries in the Northeast region passively enrolled into the Medicaid benefit. According to Ohio Medicaid, about 27,000 people are currently enrolled, with 17,000 auto-assigned. Of the 9,000 or so that voluntarily enrolled, roughly half selected to include Medicare benefits. Beneficiaries that were passively enrolled should have

received a letter this week noting which plan they were enrolled in along with information on how to change their plan or opt-in to the Medicare benefit. Beneficiaries have until April 25 to change plans and have it effective May1. Medicaid-only beneficiaries can also change plans within 90 days of the effective date of enrollment. Full benefit beneficiaries can change plans once a month. In related news, the enrollment letters for the regions that have effective dates of June 1 (Northwest, Northeast Central, and Southwest) will be mailed out Monday, March 31. Enrollment has already started for those counties. Recall that only the authorized representative or beneficiary (not payer representative) can sign the enrollment documents.

MyCare Ohio: Checking SNF resident enrollment status — Providers will be able to use the MITS portal to determine if a resident is enrolled in MyCare Ohio and under which plan; however, this information may be available only after the effective date of enrollment (May 1 for NE region). The state is not sure how far in advance of the effective date the MITS system will have the information, if at all. If providers want to check the status prior to the effective date, they may have to go through the plans. The plans will know on a daily basis of new enrollees and then it is a question of how quickly each plan updates its system. One important caveat; recall that people can change plans up to five days before the end of the month for the change to take effect the following month (April 25 for NE region). Enrollment information provided before April 25 is subject to change, so it might be best to wait until a few days after the first of the month to check enrollment status.

3/22/14- A common theme today is transition case management. In this model, individuals in nursing facilities are assessed during multiple phases to prepare, plan and follow up for a proper discharge and to try to eliminate a readmission. It has been determined that the requirements for the My Care Ohio plans is to perform care management assessments for its beneficiaries. The frequency of these assessments will depend on the condition of the individual. There are varying requirements depending on the status of the person. The minimum frequency and type of assessment will depend on the risk status of the resident. The higher risk (Based on medical condition) residents will obviously be reassessed more frequently than lower risk residents. The Intensive or (highest) will require a reassessment every 30 days, High every 45 days, Medium every 60 days, and Low every 75 days. The reassessment periods are minimums. The residents can be assessed more frequently and will also be assessed when there is a change in status. The plans will use assessment information to determine how often the beneficiaries twill need to be assessed once enrolled. Providers in My Care Ohio counties should anticipate My Care plan care management teams in their facilities to perform these assessments on their beneficiaries once the program starts. **To read additional information on the My Care Ohio plan and to see the affected regions,**

go to http://ohioaging.org/PDFs/Managed%20Care%20Panel%20PP%203-13.pdf

ODM mails first MyCare Ohio enrollment letters — The Ohio Department of Medicaid (ODM) began mailing enrollment letters to future MyCare Ohio beneficiaries located in the Northeast region this week. Beneficiaries will have 60 days to choose a Medicaid plan or be passively enrolled. They may also opt-in for Medicare benefits. The letters (view sample letter and NE insert) will be mailed to the address in the Ohio Medicaid system.

MyCare Ohio three-way agreement outlines requirements — CMS and the Ohio Department of Medicaid (ODM) have reached agreement on the three-way agreement (or contract) between CMS, ODM, and the MyCare Ohio managed care plans. The agreement covers the requirements of the plans to participate in the program and includes enrollment, marketing, services, transition rates, quality assurances, and the appeals process.

2/21/14-

MyCare Ohio is a demonstration program that will enroll Medicare and Medicaid beneficiaries located in most metropolitan counties into managed care. The program will result in a significant change to how long-term care services are provided to this population. You can view a webpage dedicated to managed care in response to this change at http://www.seniorhealthsciences.org/mycareohio.shtml . It is focused on MyCare Ohio; it provides resources and links about the program such as the rules, latest implementation timeline and regions, dates of the community forums, and a link to Ohio Medicaid's MyCare Ohio website.

2/14/14

MyCare Ohio on track for May start in NE — MyCare Ohio, managed care for Medicare and Medicaid enrollees, is on schedule for coverage to start May 1 in the Northeast region. Enrollment letters will be sent to potential members in that region beginning February 24, with passive enrollment starting April 1 and coverage beginning May 1. Members would have to voluntarily enroll in the Medicare benefit part of MyCare Ohio until January 1, 2015. Managed care plans will not be able to market their MyCare Ohio product until April 1.

BCAT to be part of new LOC assessment — The Ohio Department of Medicaid (ODM) made clear its intent to use the BCAT as a screening tool for LOC. The BCAT would be use to determine the cognitive ability of a person seeking SNF placement. According to ODM, only one percent of the current SNF and aging waiver population

would be negatively impacted by not meeting LOC using the BCAT. The state plans to do further research on that population to ensure their needs can continue to be met.

10/9/13- **State outlines plans for BIP, new LOC assessments —** The Balancing Incentive Payment Program (BIP) Advisory Committee met last week to review the schedule for BIP implementation. The BIP program pays states a higher federal match for Medicaid expenditures if certain conditions are met. In general, Ohio must implement a single entry point (SEP) for long-term care services and supports, have conflict-free case management, monitor outcomes, and use a standardized assessment form. It is also expected that Ohio will have 50/50 facility and HCBS expenditure levels for long-term care services and supports. The current plan is to RFP the single entry point, with the AAAs and other community organizations already providing support and counseling services to the elderly and disabled the most likely candidates to be awarded the contract. The plan for conflict free case management is to ensure that any SEP that provides case management does so via a completely separated part of the company. The state plans on using the National Core Indicators (NCI) project as the blueprint for outcomes data. The NCI is currently being used by the DD program and work on migrating it to the aging population has already started. The NCI will not be used for SNFs as there are already quality measures and other survey tools in place. The assessment tools are being developed to collect "core data." This is data that will be collected no matter what type of needs are required by the person (DD, MI, Aging) and will help "navigate" the individual to the appropriate services and setting. Because there is a maintenance of effort requirement, any changes to the assessment process will have to have a very limited impact on access to current service levels. As of now, the most significant switch is using two different assessments, one for children and one for adults. The child assessment, which is near completion, does not contain questions that are clearly only relevant to certain age categories. Questions only relevant to children will be removed from the adult assessment. The current "go live" date for these changes is January of 2015.

9/6/13- Data provided to OHCA by the Scripps Gerontology Center at Miami University show that the vast majority of discharges from SNFs are to the community, highlighting the important role skilled centers play in rehabilitating people and returning them to their homes. Based on analysis of MDS 3.0 data for calendar year 2011, Scripps found that 75% of all discharges with no anticipation of return were to the community. Fifteen percent of the “no return anticipated” discharges were to hospitals and another 6% were transfers to another SNF. Fewer than 2% were because of death. Scripps also analyzed all discharges, including “return expected.” Forty-four percent of total discharges were to acute care, compared to 49% to the community. A total of 102,000 SNF

patients were discharged to hospitals, of which nearly 79,000 were with return anticipated. These figures suggest that there is room to reduce hospitalizations. The 23,000 discharges to acute care with no return anticipated also merit further examination.

8/31/13- Ohio was recently awarded a grant for approximately $169M to stimulate greater access to non-institutionally based long term services and support (LTSS). This grant was made available through the Balancing Incentive Payment Program (BIP) created by the Affordable Care Act (ACA). An Ohio BIP Advisory Group has been formed to help advise on the parameters of this grant and, at their initial meeting held earlier this week, a few important highlights were shared. Ohio is one of 13 states who have been approved for BIP and, while $169M has been promoted as the additional FMAP funding, Ohio has the ability to earn more of the total $3B national BIP allocation by spending even more than anticipated on community based care. When looking at one of the key requirements to securing this grant---states achieving a benchmark of 50% of their total Medicaid expenditures on home and community-based LTSS no later than September 30, 2015--it was communicated that more than just waivers fall within the community bucket. States are also permitted to count money spent on state plan home health and personal care services, private duty nursing, state plan optional rehabilitation services, the Program for All-inclusive Care for the Elderly (PACE), and ACA state plan options to provide health homes which will encompass a consider amount of dollars within the behavioral health arena. In addition to a core standardized assessment (CSA) instrument that relates to our new NF Level of Care assessment instrument (replacement of the 3697), one of the more complex aspect of meeting the BIP requirements will be the no wrong door/single entry point (SEP) system. Ohio's SEP endeavor will coordinate around Ohio's twelve Aging & Disability Resource Networks (ADRNs) which are housed within the AAAs. It will also involve the ADRNs inviting other community agencies, from county boards to non-profits like Easter Seals to clinics, to also serve as a SEP if these entities agree to screen any and all consumers presented to them. Technology, as one can imagine, plays a huge role in ensuring the effectiveness of not only the single entry point (SEP) system, but also the core standardize assessment (CSA) instrument and therefore a $10M biennium budget allocation has been earmarked for the structural projects associated with BIP. Please note that BIP will remain a very important project for the State of Ohio and will result in permanent structural changes to our delivery system and how Ohio consumers will access all long term services and supports.

ICDS Development Continues Amid Mounting Frustration

Managed care plans participating in the Integrated Care Delivery System (ICDS) privately express concern that they still do not have the all important three way contract spelling out program requirements or the final rates that they will be paid for covering services, as well as standards for their operating systems. OHCA continues to confer with the plans and with Ohio Department of Medicaid (ODM) officials. We also have begun to reach out to the Centers for Medicare and Medicaid Services (CMS) through ODM and AHCA, as many issues remain in the federal purview. Our recent discussions with plans have focused on a set of operational questions. In addition, we are providing plans with a list of provisions OHCA would like to see in contracts with long-term care providers. Written CMS guidance on capitated integration models like Ohio’s now

addresses two key points: provider rates and coinsurance. In response to requests from AHCA, CMS now urges – but does not require – health plans to maintain provider rates at fee for service levels. This recognition that cost savings should be achieved through more efficient health care management and not through rate cuts is important. CMS also confirms that Medicare capitation payments to plans will include an amount for bad debt paid under the fee for service program and that plans are expected to pay providers without deduction for coinsurance.

It has recently come to the attention of OHCA that some counties are prorating patient liability for beneficiaries receiving hospice services. Please note that Patient Liability is not prorated if any individual is in an institution for the entire month but changers payer. Examples provided in Ohio's Medicaid Eligibility Long Term Care Training Manual include: when an individual changes from private pay to Medicaid; when an individual changes from Medicare payment or other insurance to Medicaid payment; when an individual transfers from one long term care facility (LTCF) to another LTCF, from LTCF to waiver or waiver to LTCS; and when individuals change from Medicaid to hospice or hospice to Medicaid. If any members are experiencing counties for which this practice is not being followed, please contact OHCA. We will inform the Ohio Department of Medicaid (ODM) that additional training on this particular issue in needed. We should also note that in a recent meeting with ODM auditors, OHCA learned that if counties follow incorrect patient liability prorating practices, particularly in the case of hospice, the facility is encouraged to follow the supporting 9401 documentation. Auditors will not hold facilities accountable for this incorrect practice as long as they have the supporting 9401 documentation.

8/23/13-The Ohio Department of Medicaid continues its modernization of the business process for Medicaid. While the eligibility process is being streamlined and moved online, the same plan is being developed for the level of care assessments. The entire scheme is centered around a data warehouse that will store all of the information related to Medicaid: MITS, eligibility, and assessments. Then each department, provider, case manager, or consumer will have the appropriate access and unique user interface to the data. Ultimately, everything will be able to be done online using electronic forms and signatures. In the immediate future, ODM hopes to have ODM and ODA use the same assessment and case management system that would link to DODD's systems; conduct LOC and PAS/RR determinations concurrently, and have the ability to immediately have an RN review an adverse LOC determination. There was also discussion of using telehealth instead of face-to-face meetings for some assessments. Concerns were raised about access to a broadband network or cell signal in rural areas, where the benefits of telehealth, if available, are the greatest. ODM is also looking at changing the level of care assessment forms and process, including a separate assessment for children. One issue that has been discussed at length is the definition of 24 hour supervision. ODM looked at the PIMS data to determine who is currently in Medicaid receiving services

based solely on the 24 hour supervision criteria. Of the 47,748 individuals' data reviewed, only 414 appear to only have the 24 hour criteria. Only 173 were currently enrolled and of those, only 63 were in nursing homes. The data suggests that changes to the 24 hour criteria, such as using a BCAT or GDS assessment to determine need, would have a limited impact on the Medicaid population that currently meet LOC. Next steps included testing those assessments to determine what the actual impact would be.

The budget bill provision that exempts individuals being discharged from a psychiatric hospital or psychiatric unit of a hospital from entering a nursing facility through the use of a hospital exemption was a key topic of discussion at the most recent Front Door Stakeholder meeting. Beside the minor rule changes that are needed to support this provision, the practical application of how this provision will be implemented posed a number of challenges. It was discussed that obtaining a current list of psychiatric hospitals and often updated list of psychiatric units of acute care hospitals was one key challenge. But how local Area Agencies on Aging (AAAs) and nursing facilities will be able to discern whether or not a patient was being discharged from a general medical-surgical (med-surg) floor of a hospital or discharged from the psychiatric unit of that same hospital was more challenging. Also to complicate matters was the fact that some individuals often move from the psychiatric unit of the hospital to a med-surg floor prior to discharge and how those individuals would be impacted raised another question. The Ohio Department of Medicaid (ODM) felt those individuals would still qualify for the hospital exemption for they felt the law was rather specific about being discharged from an psychiatric unit. Probable changes to the JFS form 07000 Hospital Exemption From Preadmission Screening Notification may need to be made to operationalize this new change. Stay tuned as more information becomes available. This budget bill provision is set to change September 29, 2013.

The Nursing Facility Level of Care criteria that states, "due to a cognitive impairment, including but not limited to dementia, the individual requires the presence of another person, on a 24-hour-a-day basis for the purpose of supervision to prevent harm" has been a topic of discussion for a number of months. While the Ohio Department of Medicaid (ODM) acknowledges that they are not looking to alter this criteria, they do wish to more objectively access this criteria in our new assessment instrument that will replace the current JFS Form 03697 Level of Care Assessment being created to comply with the requirements of the Balancing Incentive Payment Program (BIP). In previous NewsBites, OHCA has reported our concern with imbedding a tool called BCAT (Brief Cognitive Assessment Tool) into this new assessment instrument due to its over-simplified, non universally-accepted scoring approach to determining an individual's level of cognitive impairment and need for 24-hour support. The creators of BCAT indicated that individuals who score high enough to warrant a moderate to severe cognitive impairment (and therefore the need for supervision) often had ADLs deficits, so OHCA asked the question, "How many individuals currently meet level by only meeting the cognitive impairment/need for 24-hour support criteria?" ODM analyzed

52,634 assessments from calendar year 2010 (CY 2010) and found that of the 47,748 that qualified for our current intermediate level of care (ILOC), only 414 appeared to qualify based upon the cognitive impairment/need for 24 hour support need only. Their conclusion was very few people (less than 1%) would be potentially adversely affected by a more objective method of assessing cognitive impairment. However, Medicaid Director Dr. Mary Applegate also appeared to in step with OHCA's other concern that BCAT did not appear to be a widely accepted cognitive assessment instrument like many other tools currently used within the medical profession. And therefore, she requested that we consider the Global Dementia Scale (GDS) as the more objective assessment instrument for this tool. Please stay tuned as more information becomes available. The idea goal is to begin testing this new front door assessment instrument after January 1, 2014.

The recent report from the Scripps Gerontology Center, *Maybe Elephants Can Dance*, contains a wealth of information about Ohio's long-term care system, including data on skilled nursing centers. Confirming the changed business focus of SNFs, Scripps documents that while overall census fell by about 3,500 from 1997 to 2011, admissions increased from 130,000 to 216,000 (66%). Medicare admissions rose from 80,000 to 149,000 (86%). In terms of average daily census, Medicaid utilization fell by 4,600 over that time period, but Medicare rose by almost 5,000. An unfortunate flaw in *Maybe Elephants Can Dance* is the lack of analysis of SNF patients' discharge destination (return to home rate). This limitation likely is driven by lack of available data. The Scripps report discusses extensively the increased proportion of SNF patients under age 60, which tripled from 4% in 1994 to 12.7% in 2012. A higher percentage of these patients are on Medicaid compared to older patients. "Over the last decade-and-a-half, despite the increase in the number of those age 85 and above by almost 50%, Ohio has seen an 11% reduction in Medicaid nursing home use by older individuals. At the same time we have experienced a 26% increase in the under age 60 population using Medicaid nursing homes." Scripps finds that 26.4% of the under 60 patients have no or one impairment in activities of daily living, compared with 9.7% of 60 and over patients. A third of the under 60 patients have relatively short lengths of stay, suggesting Medicaid rehabilitation stays, but at the same time, 40% are in the SNF for more than a year. Later in the report, Scripps notes that many of the younger patients have mental illness. Another key point of the report is that Ohio's "national ranking" in long-term care balance has gone from 47th to 24th since 2004.

8/16/13-All members working with Managed Medicaid Plans should be aware that a rule change, effective July 1, 2013, slightly alters the SNF covered benefit. Traditionally, when managed care plan enrollees are placed in a nursing facility (NF), the managed care plans were responsible for all covered services until the last day of the month following the month of the member's NF admission, for a period not to exceed sixty-two calendar days. Managed care enrollees remaining in a NF after this period were to be dis-enrolled form the managed care plan and returned to fee-for-service Medicaid.

According to the Department of Medicaid, they were seeing inconsistencies in the way this benefit was being applied across the plans and were approving many enrollees return to fee-for-service Medicaid only to be discharged back to the community and re-enrolled with the managed care plans only after a week or two of disenrollment. Therefore, the Department refined the rule to say that the member may be dis-enrolled upon the request of the managed care plan in accordance with paragraph (C) or rule 5101:3-26-02.1 of the Administrative Code IF ALL of the following are met: (a) the managed care plan has authorized NF services for the month of the NF admission and for one complete consecutive calendar month thereafter; (b) for the entire period in (a) above, the member has remained in the NF without any admission to an inpatient hospital or LTAC; (c) the member's discharge plan documents that NF discharge is not expected in the foreseeable future and the member has a need for long-term NF care. OHCA recognizes that this will change some procedures and practices of Ohio's Managed Medicaid Plans.

In a potentially key development in the debate over expanding Medicaid eligibility in Ohio, the Health Policy Institute of Ohio (HPIO) and the Ohio State University (OSU) released a report asserting that the expansion can save the state billions of dollars over a period of years. Representatives from the two organizations presented their findings at a hearing of the Senate Finance Committee's Medicaid Subcommittee, chaired by Senator Dave Burke (R-Marysville). Senator Burke commended them for providing an analysis that addresses the cost issue. Some other subcommittee members questioned the results. The HPIO/OSU report may or may not pave the way for Medicaid expansion, but a key point is that the savings are achieved not through the expansion itself but by coupling it with a cap on Medicaid spending growth of 3.5-4% per year as compared to an historically derived 7.2%. Expansion itself would not limit spending growth. The state would have to take other steps along with expansion. The concern for providers with this approach is an artificial spending cap could result in greater pressure on Medicaid payment rates. The Senate subcommittee plans at least two more hearings on Medicaid over the next few weeks, and the General Assembly will return from recess in mid-September.

Ohio's new budget bill (House Bill 59) contains two provisions that affect handling of patient/resident funds in skilled nursing centers and assisted living communities. One provision is the first increase in many years in the personal needs allowance (PNA) for Medicaid patients in SNFs. The PNA is deducted from patient resources (income) monthly and reserved for the individual's personal use. The bill raises the PNA from the current $40 per month to $45, effective January 1, 2014. A second increase, to $50 per month, takes effect January 1, 2015. The PNA increases are a cost to the state Medicaid program because the money otherwise would be deducted from the rate paid to the SNF. The other budget bill provision affecting resident funds is a change to the requirement for placing residents' money into an interest bearing account. State law establishes a requirement that parallels the federal certification regulations on this issue, but has a

higher threshold. The budget bill raises the state threshold from $100 to $1,000, a change that takes effect September 29, 2013. The increased threshold does not apply to Medicare and Medicaid certified SNFs, which are still under the $50 threshold in the federal regulations, but does apply to assisted living and to non-certified SNFs.

7/26/13- The newly created Department of Mental Health and Addiction Services (MHA) released a draft of their strategic plan. The plan outlines objectives of the department, including using Money Follows the Person to move at least 500 individuals in SFY 14 and 700 in SFY 15 with SMI out of "institutional" settings and into the community. This program will be called "Recovery Requires a Community." MHA also plans on bolstering available housing by increasing funding in that area. This includes rehabilitating 80 community units and 120 new permanent housing units. The department plans on utilizing more Adult Care Facilities and Adult Foster Homes as housing alternatives. The goal is to have at least 20 percent of the homes participating. "Health Homes" will continue to be used to increase care coordination and improve outcomes for complex cases. The full draft report can be found here.

One of Governor Kasich's budget proposals that made it through the General Assembly was to create a separate Department of Medicaid (DOM). The department was carved out of the Department of Jobs and Family Services. According to the Office of Health Transformation, the language found in H.B. 59 consolidates existing authority to manage the Medicaid program under DOM. This is not a significant change given that federal regulations stipulate that each state participating in the Medicaid program have one administrative agency (formally ODJFS); however, it does create a department whose sole purpose is to administer the Medicaid program. DOM will continue to delegate responsibilities to other agencies. As more and more Medicaid services are provided via managed care, this makes DOM's primary function a contracting agency.

7/21/13- The Department of Medicaid (DOM) has indicated that the U.S. Centers for Medicare and Medicaid Services (CMS) have approved the state's applications for two waivers that are critical for the Integrated Care Delivery System (ICDS). They are called "1915(b)" and "1915(c)" waivers. They authorize mandatory Medicaid managed care coverage for beneficiaries who opt out of the Medicare portion of the ICDS of the home and community based component of the ICDS. The 1915(b) waiver is for five years, which indicates that Governor Kasich's intent to keep Medicaid managed care for the dual eligible population even after the three year ICDS demonstration ends. The Department of Medicaid is continuing to review the draft three way contract they received from CMS some time ago. The draft has not been shared with any stakeholders, including the ICDS health plans. The agency announced that $4 million in funding for outreach to potential ICDS beneficiaries is being transferred to the Department of Aging. This agency will turn the money over to subgrantees. In addition, the state is considering seeking Medicaid funding for certain ombudsman activities, including ICDS related outreach, as allowed by recent federal guidance. Beneficiaries are expected to start receiving written notification of their options in December.

Another aspect of House Bill 59- An important aspect of HB 59 provides for a different purchasing model for nursing facility services. This section allows the Department of Medicaid (DOM) to set up a special program to pay skilled nursing facilities an enhanced rate for certain high need Medicaid patients. In legislative testimony during the budget hearings, Director Greg Moody of the Governor's Office of Health Transformation presented information comparing the Medicaid cost per day in a long-term acute care hospital ($1,388) to the highest Medicare rate in a SNF ($740) and suggested a potential savings to the state of $648 per day. HB 59 allows DOM to submit a Medicaid waiver application for this program. According to the bill, the waiver would cover the period from July 1, 2013, to June 30, 2015, but the program will not begin until the state submits and receives approval for the waiver application. The program applies to "Medicaid recipients with specialized health care needs, including recipients dependent on ventilators, recipients who have severe traumatic brain injury, and recipients who would be admitted to long-term acute care hospitals or rehabilitation hospitals if they did not receive nursing facility services." The bill also indicates that the program will include provisions for improved outcomes, criteria for identifying appropriate patients, and incentives for placing the patients in SNFs. There is no timeframe for DOM to submit the waiver application.

Governor Kasich and the Office of Medical Assistance (Ohio Medicaid) have announced that Ohio has been awarded a grant for approximately $169M to stimulate greater access to non-institutionally based long term care services and supports (LTSS). The grant is part of the Balancing Incentive Payment Program (commonly known as the Balancing Incentive Program or BIP) that was made available to states under the Affordable Care Act. To participate in BIP, states must achieve a benchmark of 50 percent of total Medicaid long-term care expenditures on home and community-based services by September 30, 2015. In addition, states must also adopt three standard operating protocols to improve care for individuals by September 30, 2105.The three protocols include: the establishment of a no-wrong-door/single-entry-point system for beneficiaries; implementation of case management services that are free of conflicts of interest; and core standardized-assessment instruments. The grant provides for an additional 2% enhanced FMAP on all community-based LTSS beginning July 1, 2013 through September 2015. It will be paid to the states on a quarterly basis and will be based on the actual amount spent on non-institutional LTSS.

7/8/13- Ohio recently selected a new provider oversight contractor for providers who deliver services to individuals on the Ohio Home Care Waiver and Transitions Carve-Out Waiver. The organization that was awarded the statewide provider oversight contract is Public Consulting Group Inc. (PCG). To view information on it, go to http://www.ohiohcp.org/Letter-NewProviderOversightContractor.pdf

Also, Effective July 1, the Department of Medicaid adopted emergency rules raising

Assisted Living Waiver and PASSPORT (and also Choices waiver) provider rates. For the Assisted Living Waiver, the new rates for each tier, showing an increase of approximately 3%, are as follows:

Tier 1 $49.98
Tier 2 $60.00
Tier 3 $69.98

For PASSPORT, the rate for personal care services will increase to $4.34 per 15 minutes and for homemaker services to $3.84 per 15 minutes. The rates for other PASSPORT services also are increased by 1.5% according to the schedule the department adopted.

Also, as we have discussed in our previous news, a new assessment instrument will be replacing the current level of care instrument ODJFS 3697 **3697** and will be used to determine all individuals for waivers and NF admission functional eligibility for services, identify their health and psychosocial needs, and develop a comprehensive service plan to meet those needs. This work is being done in response to BIP's requirements for standard operating protocols specifically having a single entry-point system and core standardize assessment instrument.

6/1/13- The Launch of Ohio's ICDS is postponed until 3/1/2014- http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=G8lgrCOtjJU%3d&tabid=105

5/7/13- The plan to turn care of more than 100,000 dual eligible individuals over to managed care companies is being renamed My Care Ohio. After months of delay, the state received a 200-page draft of the three way contract between the plans, the state, and the federal Centers for Medicare and Medicaid Services (CMS). In addition, CMS provided draft payment rates for the plans, which are expected to be finalized within 2-3 weeks. The first of three phases of readiness review – which assesses the ability of the managed care plans to begin operating – was sent in writing to the plans. The state also is negotiating with CMS on a detailed enrollment guidance document. It was emphasized that plans will have to enter into a payment agreement with any SNF that provides care for an enrollee, whether the SNF is in network or not, and that the payment floor for Medicaid is the facility's Medicaid rate. Individuals in the ICDS (Integrated Care Delivery Service) can stay in their current SNF for the entire three year duration of the demonstration.

5/1/13-**H.B. 59: Institutionalized SMI population remains a target —** The new department that would be in charge of mental health and drug addiction services will continue the charge to move individuals out of nursing homes and into the community. Current successes, such as the waiver program for SMI individuals, have moved more than 800 individuals. The administration plans on allocating more funds to housing, as this is a barrier to transitioning more people with SMI, especially in rural areas. Two other initiatives related to the SMI population in nursing homes stand out in H.B 59. The

first is a "money follows the person" approach that has been used for all nursing home individuals looking to move onto community waivers. This allows funding to "follow" the person into the community and pay for community based services. The second, and more interesting of the two, is the requirement that all psychological hospitals perform a PAS (Preadmission Screening) on residents prior to being discharged to a nursing home. This basically eliminates the hospital exemption currently in place. However, it is uncertain if an individual that meets the Hospital Exemption Criteria but doesn't meet level of care could be admitted. These changes, coupled with the current push to change the LOC criteria to make it harder for the SMI population to meet, clearly show the desire to integrate more individuals with SMI into community settings.

Debate over use of BCAT for level of care continues (Also 3/19/13 information below). A subgroup of the Front Door Workgroup that is charged with making changes to the level of care criteria held a conference call with Dr. Mansbach, one of the creators of the BCAT, to discuss its use as a LOC tool to define "24 hour supervision due to a cognitive impairment." Dr. Mansbach noted that there is confidence on a cut-off point for when a person would need 24 hour supervision (around a score of 22 or below); however, he also agreed that a person scoring above that threshold may need 24 hour supervision and that other information is needed to make that determination. Dr. Mansbach also noted that the BCAT may not have reliable results if the individuals is showing symptoms of SMI such as hallucinations. Many groups have expressed concerns over using the tool as a strict LOC criteria. The full workgroup will meet in May to further discuss the issue.

4/19/13- Last Thursday, the Ohio House of Representatives passed its biennial budget; like its counterpart to the north (Michigan), the House excluded funds for the Medicaid expansion from the bill, despite the fact that Gov. John Kasich supports the expansion.

3/9/13- **The Front Door Workgroup met this week to continue discussions related to a new Level of Care (LOC) tool to determine a person's nursing facility (NF) eligibility. The tool that is being implemented will not change the current criteria that makes an individual eligible for a NF or community based services such as the PASSPORT home care program. Two criteria that are being examined with this new tool are behavioral health issues and cognitive impairments (like Dementia). Some of the questions on the new tool will be taken from the AC-OK Screen for Co-Occurring Disorders-Mental Health. You can see more information on this screen at http://www.thecenters.us/CentersPages/CentersCOD_FAQ.html. Diane Dietz of the OHCA reported that "In a meeting earlier in the week with the Front Door Stakeholder Group of the Unified Long Term Care Advisory Workgroup, movement continued on the completion of two new level of care (LOC) assessment instruments--one for children (consumers up to age 21) and another for adults. While the children's LOC instrument, which is being based on a tool used in Wisconsin, is close to reaching consensus, the adult assessment instrument still has**

a few key issues to resolve. As reported in previous News Bites, the State of Ohio is interested in embedding a cognitive assessment tool called BCAT (Brief Cognitive Assessment Tool) into the adult assessment instrument. It is their goal to more objectively determine the current LOC cognitive criteria which is used to trigger a consumer's access to an institutional LOC.Currently, our cognitive criteria triggers an institutional LOC if a consumer, due to a cognitive impairment, requires 24 hour support to prevent harm. Ohio was feeling that the BCAT could be used to objectively determine that criteria. Specifically, if the assessment tool produced a score above a certain number, the consumer was cognitively impaired enough to require 24 hour support to prevent harm. Below a certain number, while the consumer may indeed be mildly cognitively impaired, 24 hours support would not be warranted and therefore the criteria would not be met. After talking with a few physicians about the BCAT and this "more objective way" to determine the need for 24 hour support, OHCA raised some serious concerns. We expressed while the BCAT may be an fine tool to help assess someone's cognitive impairment, medical evidence says that no one specific test, particularly taken at one particular point in time, can confirm a cognitive impairment diagnosis. Furthermore, the aspect of needing 24 hour support--which is the real criteria for meeting an institutional LOC--equally can not be determined by a score on a test. While on any given day, a cognitively impaired resident may be able to count backwards or visually recognize a telephone versus a set of keys, tools like the BCAT can not definitively determine if the consumer is going to remember to turn the stove off or remember that if they don't take their medicine it can indeed cause harm. Many on the committee agreed that this tool may indeed be a good tool. But it cannot be used as a scored determination for 24 hour support. Finding a way to identify a pattern of behavior that elevates someone's risk to themselves or others is more desirable.The State asked that we continue this discussion with interested committee members and OHCA together with our physician supports".

With regard to cognitive impairment, the discussions focused around the criteria that she be used to determine what makes an indvidual require the need for twenty-four hour supervision. Discussions on this topic focused on the BCAT tool, which stands for the Brief Cognitive Assessment Tool. You can see more information on it at http://www.thebcat.com/about_bcat.php**. In a future meeting, a full presentation will be made to the Front Door Workgroup on this instrument. It is believed that by the Fall of 2013, the workgroup will have a new tool to replace the current** 3697 **form.**

3/7/13- **The Department of Aging testified before the House Finance Human Services Subcommittee last week. You can view the testimony at** http://www.aging.ohio.gov/resources/publications/t_20130226.pdf

The budget calls for an increase in adult day service rates by 20% and increase the rates for assisted living to $49.93 for tier I, $59.95 for tier II, and $69.96 for tier III.

Overall, the Department plans on spending an additional $2 million that it believes is necessary to ensure access to these services.

2/8/13-**Two proposed changes from Governor Kasich's proprosed budget that are intended to lower the number of individuals under age 60 with mental illness who receive long-term care in SNFs:**

- **State dollar savings from moving a planned 1,200 individuals out of SNFs will be used to pay for non-Medicaid supports in the community (e.g., housing vouchers).**
- **Patients discharged from psychiatric hospitals or units will have to go through a Level 2 PAS before being admitted to a SNF and will not qualify for a hospital exemption.**
- **To see more information, go to http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=Us282DLpPf0%3d&tabid=124 and**

http://www.healthtransformation.ohio.gov/Budget/Budget1415.aspx

12/18/12- Metrohealth Still Awaiting Medicaid Waiver- http://www.metrohealth.org/body.cfm?id=4736

12/12/12- **Kasich Administration Announces State-Federal Agreement on Coordinated Care Delivery Program for Ohio Seniors -** http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=X_sOK4xbdD4%3d&tabid=105

12/2/12- Deep cuts in funding strain Ohio care facilities; http://www.vindy.com/news/2012/dec/02/deep-cuts-funding-strain-care-facilities/

11/21/12- This is an interesting article that we have come across- http://www.disabilityrightsohio.org/news/ledfort-class-cert-apr-2012 Portion of VA benefits cannot be counted toward Medicaid waiver income determination.

11/16/12- Ohio has received a draft Memorandum of Understanding from the U.S. Centers for Medicare and Medicaid Services for the Integrated Care Delivery System (ICDS). State Medicaid Director, John McCarthy, indicated this week that he expects the agreement to be signed by the end of November or December. He also stated that the ICDS will not begin in April or May 2013, but he cannot set a specific start date at this time. His office is meeting regularly with the Medicaid HMO companies who will be participating in the ICDS to discuss the ongoing developments. Ohio is expecting to have a draft of the Medicare capitation rates by the end November, 2013. The HMO's will then l have a better idea what they will be paid.

11/15/12- Are you responsible for a parent's nursing home bill? http://finance.yahoo.com/news/responsible-moms-nursing-home-bill-080045548.html

11/12/12- INTERACT- (Interventions to Reduce Acute Care Transfers) is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital- Learn more at http://interact2.net/

11/8/12-Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. See more at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

11/3/12- For General Medicaid Provider Information on Ohio Medicaid Health Homes for Individuals with Serious and Persistent Mental Illness go to http://emanuals.odjfs.state.oh.us/emanuals/GetDocument.do?doc=Document%28storage%3DREPOSITORY%2CdocID%3D%23Ref_MHTL3334_12_05%29&locSource=input&docLoc=%24REP_ROOT%24%23Ref_MHTL3334_12_05&username=guest&password=guest&publicationName=emanuals **-**

For Information on how Ohio is improving Long term services and supports, go to http://jfs.ohio.gov/OHP/HomeChoice/HCBS_Rebalancing_Trends.pdf

10/20/12- Ohio has not released any specific postponement of the April 1, 2013, implementation date for the ICDS (Integrated Care Delivery System), however the delay in a federal approval of Ohio's proposal will definitely affect when the program begins. With the start-up of the ICDS, indviduals who are dualy eligible (Medicare/Medicaid) will have a 60-90 day window in which they will choose from 2-3 managed care plans or opt out of the managed care for their Medicare benefits.

Medicare primary payor or secondary payor- see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MSP_Fact_Sheet.pdf **for assistance in determining this matter.**

For the Centers for Medicare and Medicaid open door forums go to http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_SNFLTC.html

10/12/12- Open enrollment for Medicare, including Medicare Part D plans, starts Monday, Oct. 15, 2012. Visit www.medicare.gov or call **1-800-MEDICARE (TTY 1-877-486-2048)**

10/11/12- The Office of Health Transformation provided information of their most

recent ICDS (Integrated Care Delivery System) presentation to provider stakeholders. You can view it at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=vh-DgHIkK9g%3d&tabid=105

****Because of protest and litigation issues against the managed care plans that cover Medicaid only consumers in Ohio, State Medicaid Director John McCarthy announced a delay of the effective date of the new plan selections until July 1, 2013. Again, the delay applies to the existing managed care program for Medicaid-only beneficiaries and does not apply to the new Integrated Care Delivery System (ICDS) for dually eligible beneficiaries. The ICDS Memorandum of Understanding between Ohio and the U.S. Centers for Medicare and Medicaid Services still has not been finalized, and Director McCarthy has stated that the planned April 1, 2013, implementation date may be delayed, but no official announcements have been made for the ICDS.**

10/6/12- The Ohio State Bar Foundation's Fellows Class of 2002 presented the Light the Way: Don't Leave Your Loved Ones in the Dark campaign - to tell Ohioans how important it is to plan for health care decisions before a crisis. http://www.osbf.net/advancedirectives/index.html**.**

9/25/12- The timeframe for ICDS (Integrated Care Delivery Sytem) implementation is still on schedule with the following start dates: April 1, NW, NEC, EC regions; May 1, NE region; and June 1, C, WC, and SW regions. See a better explanation at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=-4WZ6OPj-Jc%3d&tabid=84 **. An enrollment broker will be used to do the actual enrollment, with all enrollments going through that broker. Consumers who are eligible for the ICDS will receive a notification letter 90 days prior to the enrollment date for that region. A second letter will be sent 60 days prior to the enrollment date, and a final letter 30 days prior to the enrollment date. Consumers can opt-out of the Medicare part of the ICDS initially or at anytime beginning the first of the month. Consumers must be enrolled in the ICDS for Medicaid services. The state is still working with CMS on the memorandum of understanding. Outstanding issues include the rates the state will offer the managed care plans and if managed care plans can market directly to consumers. The state also provided more information on the ICDS community waiver . One area of the health care delivery system that the ICDS is expected to have a significant impact on is the 1915(c) HCBS waiver (PASSPORT program). As many as 80% of the current waiver recipients in an ICDS county may be enrolled into the ICDS system. As indicated below (see 9/7/12 note), the state has proposed to CMS the creation of a separate 1915(c) waiver for the ICDS population.**

9/18/12- For a review of the initiatives that are under development for the next

Ohio budget and health care payment reform go to http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=hfYcdFXxlVc%3d&tabid=84

9/17/12- CMS approves Ohio's state plan amendment to create health homes for people with mental illness – As noted on the website, A health home is not a building; it is a coordinated, person-centered system of care. An individual who is eligible for health home services can obtain comprehensive medical, mental health and drug and/or alcohol addiction treatment, and social services that are coordinated by a team of health care professionals. See more at http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/health-home-committees.shtml

9/7/12- The State of Ohio reported that the single waiver project (which was supposed to combine PASSPORT, The Ohio Assisted Living Waiver, Choices, The Ohio Home Care Program and the Transitions Carve Out portion of the Ohio Home Care Waiver) has been indefinitely postponed in lieu of creating a new 1915 (b)/(c) waiver that will provide HCBS (Home and Community Based Services) to individuals who require a NF level of care but are participating in the ICDS (Integrated Care Delivery System) demonstration. This new waiver would offer a service package consistent with the services available in Ohio's five NF-based LOC waivers but would be mandated to be administered through a managed care program and allow for the limitation of providers through selective contracting. The implementation date is scheduled for July 1, 2013. Current waiver clients who enroll in the ICDS will move to this new waiver and Ohio estimates that by the third year of the demonstration 41,700 consumers will be served through this new waiver. This new waiver is also proposing no cost caps similar to those seen with PASSPORT. The new waiver will use a cost formula similar to DD (Developmental Disability) waivers. In that formula, it is dependent on the individual needs but, on average, would need to cost less than a nursing facility stay. In addition, all LOC determinations and redeterminations of waiver consumers will be performed by a separate entity under contract with ODJFS and not the AAA's (Area Agencies on Aging). The AAAs will perform waiver service coordination and will be required to serve all ICDS consumers over the age of 60. This new waiver is on a fast track to coincide with the April 1, 2013 proposed implementation of the ICDS. Ohio plans to submit their waiver proposal to CMS by October 1. A copy of the first draft can be reviewed http://www.longtermcareohio.com/downloads/Integrated%20Care%20Delivery%20System-%20Started%20April%201,%202013.pdf

9/5/12- The New Hospice Payment System Fact sheet is avaialable at

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/hospice_pay_sys_fs.pdf

At a recent meeting of the Nursing Facility Reimbursement Workgroup, Director Greg Moody of the Governor's Office of Health Transformation said one of the Kasich Administration's highest priorities in examining SNF reimbursement is to find ways to move people with severe mental illness out of SNFs and into the community. He set a goal of completing the process within 6 years. In the same meeting, State Medicaid Director John McCarthy commented that he is very concerned about excess bed capacity in SNFs because, in his opinion, SNFs are admitting "inappropriate" patients such as individuals with mental illness to fill beds.

It appears that Mr. Bill O'Boyle's work from 2007 is finally getting the attention is deserves. See the related article below to review.
http://mentalhopenews.blogspot.com/2007/10/nursing-homes-warehouse-homeless.html

8/18/12- At a SNF Reimbursement meeting this week, Office of Health Transformation Director, Greg Moody, told the workgroup that one of the administration's greatest concerns is Medicaid skilled nursing facilities housing individuals with mental illness. Medicaid Director McCarthy added that he feels excess bed capacity among SNFs results in inappropriate admissions, so he would like to reduce the excess. Director Moody set a timetable of six years for relocating the mental health population to the community, although he acknowledged that community capacity presently does not exist.

8/15/12- Update on NF LOC (Level of Care) information-The Front Door Stakeholder Workgroup of the Unified Long Term Care Advisory Group-

1. **New assessment LOC tools are being developed for both children and adults.**
2. **There are thoughts of combining Protective LOC and Skilled LOC into Intermediate LOC.**
3. **ODJFS was granted permission to explore a 1915i waiver which would allow Ohio to provide HCBS as a state plan service to individuals with less than an institutional level of care. This would eliminate Protective LOC.**
4. **Unlike Ohio's other 1915c waivers, like Passport, 1915i waivers may not limit the number of eligible participants or have a waiting list.**
5. **Time Limited LOC's are also being considered again.**

7/30/12- The Summer Home Choice Bulletin is now available. You can view it at

http://www.carestar.com/upload/images/HOMEChoiceBulletinSummer2012V4_Issue2.pdf

7/17/12- 2012—The Last Chance for Effective Estate Planning? See http://www.jdsupra.com/post/documentviewer.aspx?fid=ea176a85-205f-4059-a1df-a636196f8f7e for information.

6/27/12- Additional news on the state's proposal for an Integrated Care Delivery System **(ICDS) demonstration project- proposal for an Integrated Care Delivery System – We mentioned this on April 2, 2012. Selected counties in Ohio will be participating-** regions **. Also view Final ICDS Proposal - Ohio and the U.S. Centers for Medicare and Medicaid Services are moving forward with Ohio's proposed Integrated Care Delivery System (ICDS). The Ohio Office of Medicaid currently is reviewing applications from 10 managed care companies to serve the seven Ohio regions covered by the ICDS. The decisions on which managed care plans will cover which** regions **should be issued soon. Providers in the ICDS counties will deal with two plans, and the plans will be different among regions. It has been indicated that one plan can cover no more than three regions. An individual will not begin to be covered by a managed care plan until they become dually eligible. For example, if a person is admitted to a Medicaid certified nursing facility for a Medicare stay and is not already on Medicaid, they do not move into the managed care plan until or it they later become eligible for Medicaid. Even then, there will be a period of Medicaid fee for service coverage while the individual is enrolled in managed care. The indication is that the begin date for the ICDS will be April 1, 2013, but it is likely that the seven regions will enter the program in a staggered fashion.**

6/15/12-Update on LOC (Level of Care)- As we have mentioned before, a new LOC assessment instrument will be created in Ohio to serve the purpose of determining eligibility nursing home and waiver eligibility, identifying an individual's support needs and forming a service plan. It has been established that the LOC eligibility portion of this more comprehensive assessment instrument will be a stand-alone module and that there will be separate modules to determine children's LOC eligibility and to determine consumer needs and service plan.

With respect to the assessment instrument, Ohio is beginning to research a popular assessment instrument called InterRAI, which is modeled after the MDS, and is the basis for assessment instruments in the states of Michigan, Washington, New Jersey, New York and Wisconsin. This instrument assesses degrees of need within ADLs and IADLs (limited, extensive, maximal/total) which is different to the Ohio eligibility instrument

(ODJFS 3697 see it at **3697 -page 3**) which measures independent, supervision and hands on. The Front Door Stakeholder Group determined that while an assessment instrument like this would be ideal for determining need and service plan, However, they believe that eligibility should not be related to degree of assistance. Assistance at any level should make a consumer eligible in a particular ADL. Other discussion points included: adding communication as an ADL; how to account for service dependency (whereby absent a service/support, the consumer is at risk for institutionalization); making ILOC and SLOC just NF LOC at the intermediate level, and broadening our view of 24-hour support.

6/1/12- Additional news the state's proposal for an Integrated Care Delivery System (ICDS) demonstration project- Final ICDS Proposal – We mentioned this on April 2, 2012. Selected counties in Ohio will be participating. You can see them in the proposal indicated above.

The Request for Information (RFA) has been issued and 10 health plans have responded with selection of plans and finalization of the MOU (Memorandum of Understanding) anticipated for the end of July, 2012. It had been mentioned previously that a staggered enrollment would occur however, a staggered enrollment process was not accepted by CMS (Center for Medicare and Medicaid Services), and the agreed upon date for statewide enrollment (again only in the selected counties) would begin April 1, 2013. In addition, ICDS enrollment will occur through an enrollment broker. Advocacy groups, such as the Ohio Olmsted Task Force, have offered to assist in this process.

In August or September, for the regions of the State who have not been selected for the ICDS, Ohio will send out a request for proposals (RFP) for case management services for the JFS-administered waivers (Passport, Assisted Living, Ohio Home Care, Choices). More than one vendor will be selected for each of the State's regions, which are yet to be determined. The State is encouraging interest from various organizations and in particular from those who have other business outside case management.

With the Affordable Care Act – (You can see some key features of it at http://www.healthcare.gov/law/features/index.html**) and the new group of individuals to be served (consumers with incomes up to 133% of the federal poverty level), Ohio will be submitting a 1115 demonstration waiver for simplified and streamlined eligibility. This will only impact community adults and not those who are seeking any home and community based waiver services, or NF institutional services where spend-down still remains an important component. A 30 day comment periord will be set up with additional public meetings to discuss the plan.**

5/25/12- Many states have struggled to transition elderly and disabled individuals from institutionalization to community-based living arrangements. Ohio has also struggled but it has had more success than most other states. See http://www.disabilityscoop.com/2012/05/25/states-struggle-goals/15709/

5/19/12- Beginning in October, 2012, Medicare can withhold a portion of payments to hospitals that have high readmission rates for patients with certain conditions such as heart failure and pneumonia. Many of the Area Agencies on Aging in Ohio are beginning what is called Care Transitions to help hospitals with this issue. The Center for Medicare and Medicaid Services (CMS) has already contracted with some Area Agencies on Aging in Ohio and working with others to provide coaching to hospitalized seniors on how to get home, stay healthy, and avoid return visits to the hospital. You can view more information on Care Transitions at http://www.healthcare.gov/compare/partnership-for-patients/care-transitions/index.html and http://www.caretransitions.org/What_will_it_take.asp

5/5/12

Single Waiver Information

– Ohio is in the process of developing a Single Waiver **Waiver Benefit Package** that will combine many of the current waivers for long-term care such as PASSPORT, Choices, and Assisted Living. Part of that process is developing the benefit package that will be available to consumers that quality for the waiver. The Single Waiver Subcommittee of the ULTCSS Advisory Board has the task of developing those benefits. The group met during the first week of May, 2012 to discuss the possible supports that will be included. The following current supports will remain available: Adaptive/Assistive Devices and Medical Supplies, Environmental Modifications, Social Work/Counseling, and Community Transition Services. The group discussed the possible addition of:

1. Telehealth - This is the use of technology that involves ongoing monitoring and reporting system;

2. Nutritional Counseling - This involves individualized guidance to a consumer who has special dietary needs. This is similar to the services currently offered under the Home Choice program.

3. Independent Living Skills Training Person- This is a training for those who need to learn basic home management skills and how to live safely and independently in the community.

4. Chronic Disease Self-Management – This is an evidence-based training module that follows a scripted curriculum to help newly diagnosed individuals manage their disease. It is usually taught by someone with the disease.

5. Goods and Services- This is a "catch-all" category for supports that do not easily fit into the other categories. The service must fit into the goals of the service plan and help the person become or remain independent, become community integrated, or substitute human assistance.

Besides the discussion that occurred this week, the administration is currently accepting comments on the proposed services and supports to aid in determining the final benefit package. The single waiver is currently slated for implementation towards the middle of next year.

4/20/12- The five plans that were approved to receive statewide contracts for the combined $5 billion Aged, Blind, and Disabled and Covered Families and Children group are CareSource, Aetna, United Healthcare, Meridian, and Paramount.

As we have previously mentioned, Ohio is revising the Level of Care (LOC) criteria, the first phase was updating the PASRR rules (2009), the second was updating the LOC rules (March 2012), the third phase will be th implementation of an IT Instrument (Approximately, July, 2013). The Money Follows the Person (MFP) Advisory Workgroup met this week to discuss changes to the Level of Care (LOC) criteria. The group is not looking to make the criteria more restrictive, but instead is looking at ways of adding broader criteria or changing current criteria to reduce service gaps or barriers to transitions. The group identified additional criteria or needs to investigate implementing in Ohio, including:

1. **Risk of institutionalization**
2. **Adding specific medical conditions**
3. **Changing or broadening mobility/locomotion definition**
4. **Changing the cognitive impairment definition**
5. **A more detailed definitions around personal services**
6. **Consider adding employment; and**
7. **Consider adding wheeling or wheelchair use.**

The group also discussed the objective of the LOC as it relates to functional versus clinical assessment and how it relates to the outcome of the assessment process. Mercer, the consultant group that will be putting together the IT tool to collect the data and make the determinations, noted that states use different algorithms that vary in their results and how they are used.

4/13/12- From McKnights, **New Medicaid regulations give states flexibility with home and community based services** http://www.mcknights.com/new-medicaid-regulations-give-states-flexibility-with-home-and-community-based-services/article/235920/

On April 12, CMS issued a final rule that revises the Medicare Advantage program regulations and prescription drug benefit program regulations to implement new statutory requirements; strengthen beneficiary protections; exclude plan participants that perform poorly; improve program efficiencies; and clarify program requirements.

4/2/12- On April 2, the state's Final ICDS Proposal (ICDS) demonstration project was released.

Some highlights of it include;

1. The program will be rolled out into the seven different regions beginning in February, 2013
2. Health plans will not be able to retroactively deny prior authorizations
3. Only individuals enrolled in both Medicare and Medicaid will participate in the

ICDS
4. Medicaid eligibility and assessment process will not change
5. ICDS health plans are to incorporate innovative provider reimbursement methodology that rewards quality in their RFA responses and,

6. Under 18, MR/DD on a waiver or in an ICF-IDD, PACE participants, duals with third party health care coverage, and delayed Medicaid spend down are exempt from the program.

The Ohio Association of Area Agencies on Aging supports the inclusion of the Area Agencies on Aging in the Governor's Office of Health Transformation proposed Integrated Care Delivery System (ICDS). See Letter from AAA

Also, For the new Proposed Waiver Benefit Package, go to **Waiver Benefit Package**

For new proposed Nursing Home Resident' Rights for Transfers and Discharges, go to NH Resident's Rights

For the New State Proposal to Integrate Medicaid and Medicare, go to Medicaid/Medicare Integration

- New Medicaid Level of Care (LOC) Rules are currently effective as of March 19, 2012- 3/16/12- New LOC Rules and information are available at New LOC Rules

For the new LOC Rules Powerpoint, go to Powerpoint

See ODJFS Director McCarthy's Testimony on upcoming Long Term Care Changes at, Testimony**.**

Also see the timeline for changes at Timeline.

2/19/12- To Locate Ohio Nursing Home, Abuse, Neglect and Deficiencies, go to http://www.iqnursinghomes.com/Ohio-Nursing-Homes--1-OH.html

2/13/12 - Ohio is Moving Forward with Managed Care Plan- On Monday 2/6/12, State Medicaid Director John McCarthy convened a meeting of stakeholders to receive comments on the state's proposal to integrate Medicare and Medicaid services for dually eligible individuals. Reportedly one of several sessions with different categories of stakeholders, Monday's meeting was limited to facility-based provider groups,. Federal guidance on integration proposals requires meaningful stakeholder participation in development of the plan. Groups have commented to

Director McCarthy both verbally and in *writing*, expressing serious concerns about the state's decision to adopt a managed care model and supporting the alternative, a managed fee for service model. Federal guidance allows states to use either approach to integrate Medicare and Medicaid funding. Most of the provider groups present also voiced varying degrees of concern about the direction the state has proposed, although some just had questions. In response, Director McCarthy argued steadfastly for managed care, saying that most of the issues raised by the provider groups could be addressed through the state's contracts with the managed care plans. He explained that the managed care model allows the state to share in a defined amount of savings (including Medicare money) up front, while the managed fee for service approach yields savings – if any – after the fact. Director McCarthy also told us that under the managed care model, the federal timetable for Medicare Advantage plans applies. This timetable specifies that the Medicare Advantage plans must be approved by September and that coverage will begin January 1, 2013. Director McCarthy also reported that the state is considering the eight existing Medicaid managed care regions for use in the duals project. The next steps are not clear, as Director McCarthy concluded the meeting without scheduling any future discussions other than the Unified Long-Term Care Systems Advisory Workgroup meeting in March. We understand from federal guidance that states' proposals to the Centers for Medicare and Medicaid Services must be filed by late spring or early summer, although Ohio has not revealed the exact timing of its submission.

2/11/12- The Ohio Department of Jobs and Family Services will be holding webinars in March that will cover the new level of care rules. Once we are aware of the dates/times we will post that information. Also, for the new enrollment process for Ohio's Choices Program, go to Choices and New Definitions for Ohio's Medicaid Assisted Living Waiver, go to Assisted Living.

2/8/12- To view the latest report on selected indicators of care and services being provided to nursing home residents in Ohio, go to Nursing Home

1/28/12- Information on the proposed Health Home for mentally ill individuals is available at Health Home, Mental Health and News Release

1/17/12- For the New Medicaid and Medicare Income Guidelines, go to Guidelines

1/13/12- **The Ohio Department of Aging (ODA) is in the beginning process of attempting to automate the Pre-Admission Screening and Resident Review (PASRR) form ODJFS 3622. State administrators have held discussions around the process of using a web application to fully automate PASRR. They are in the process of seeking input from nursing homes, hospital providers and the Passport Administrative Agencies to make sure the web application is as functional as**

possible. There is no timeline for implementation as the department continues to explore different approaches and hold discussions with those involved in the PASRR process.

1/11/12 - For the Draft Model Design for and Integrated Care Delivery System in Ohio For Individuals Enrolled in Both Medicare and Medicaid (AKA Strawman Proposal), go to Proposal. For more information, also go to Strawman

1/6/12- Medicaid bed hold reimbursement changes took effect January 1. Medicaid certified nursing facilities (NF's) who had an occupancy rate greater than 95% in the previous calendar year will still receive 50% of their Medicaid rate as payment for a bed hold day. NF's with less than 95% occupancy in the previous calendar year will receive 18% of their Medicaid rate. The maximum bed hold days a resident can have in a calendar year is still 30. Also, there appears to be a delay in the proposed single waiver. The timetable has been pushed back to 11/1/12 from 7/1/12. According to ODJFS Director, John McCarthy, "The administration has backed away from that aggressive timeline to allow more time for input from the people who will be served by the single waiver". There are also federal guidelines that need to be to approved to move forward with the single waiver as well.

12/21/11- We had a very informative discussion with Bonnie Kantor-Burman, Director of the Ohio Department of Aging, this morning (We want to thank Bonnie for taking the time out to do this for us). In our discussion, she wanted to make it clear that it is not necessarily a Managed Care organization who will be taking over when the State of Ohio goes to a Single Waiver process in 2012. She indicated that it is more of a semantic issue that has led to this confusion. Also, she made it clear that The Ohio Department of Aging, as well as all stakeholders involved, are doing their due diligence to make this a successful process. It is a coordination of care process that will be put in place and all avenues will be explored with the main goal of providing the appropriate care to all that require it in the best possible fashion. (See information of the Single Waiver Initiative at Single Waiver). She indicated that she will provide www.longtermcareohio.com with a clarification/update on the process that is currently being worked on as soon as possible. As soon as we receive it, we will post it for you. If you have any questions on the proposed change in Medicaid reform, you can contact John McCarthy, Medicaid Director at ODJFS at 1-614-466-4443 or by email. (read Mr. McCarthy's 12/20/11 testimony on Medicaid reform plans at Medicaid Reforms) , **Greg Moody at The Office of Health Transformation at Greg.moody@governor.ohio.gov** or **Bonnie Kantor-Burman at Department of Aging at 1-800-266-4346 or 1-614-466-1055.**

You can view more information on the single waiver proposal and level of care changes at Single Waiver - The revised Level of Care (LOC) rules are considered Phase 2 of the Front Door Project, which includes the updating and re-writing of rules to provide short-term system balance related specifically to an individual's

level of care.