

**STATE OF OHIO
COMMUNITY BEHAVIORAL HEALTH
MEDICAID BUSINESS PLAN**

AUGUST 2004

**State of Ohio
Community Behavioral Health
Medicaid Business Plan**

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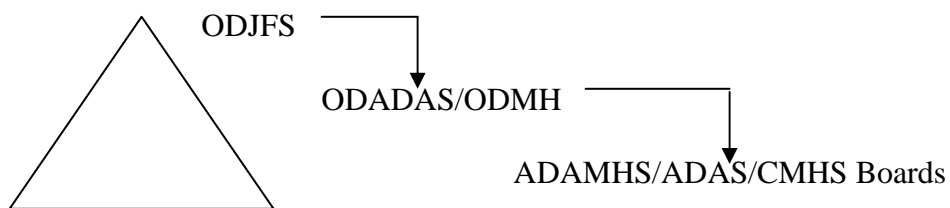
A. Introduction

The Ohio Department of Alcohol and Drug Addiction Services (ODADAS), the Ohio Department of Mental Health (ODMH) and local Alcohol, Drug Addiction and Mental Health Services (ADAMHS), Alcohol and Drug Addiction Services (ADAS) and Community Mental Health Services (CMHS) boards have been challenged with developing a design for an improved community Medicaid behavioral health program.

Medicaid is a federal/state program that is administered at the state level through the designation of a “single state agency”. The single state agency in Ohio is the Ohio Department of Job and Family Services (ODJFS). ODJFS administers and/or supervises the administration of the entire Medicaid program. ODJFS has the authority to promulgate rules that are binding on other state and/or local agencies that may administer a portion of Ohio’s Centers for Medicare and Medicaid Services (CMS) approved Medicaid state plan. ODJFS is directly responsible to the federal government for all aspects of subrecipient responsibilities.

ODADAS and ODMH are subrecipients of ODJFS. ODADAS is responsible for administering the community Medicaid alcohol and other drug treatment program at the state level while ODMH is responsible for administering the community Medicaid mental health program at the state level. A subrecipient relationship is established through an interagency agreement between ODJFS and each of the other two departments. ODADAS and ODMH then establish a subrecipient relationship, through a standardized contract with local ADAMHS/ADAS/CMHS boards for local management of the program. ODADAS and ODMH oversee the local management of the program by the boards. ODJFS has ultimate oversight responsibilities for the administration of the community Medicaid program by ODADAS and ODMH.

At each level of administration and management (ODJFS, ODADAS/ODMH, and local boards) there are essential activities that must occur to assure that the community Medicaid behavioral health program is in compliance with all federal and state Medicaid requirements.



This business plan outlines the components necessary for efficient and consistent administration of the community Medicaid behavioral health program at the state and local level. A brief outline of each component is described. Many additional details will be added as work on each component continues. However, the intent of the document is to establish the overall direction of the administration of the community Medicaid behavioral health program.

While not specifically addressed in this business plan, it is recognized that a number of activities and initiatives occurring in the system either involve Medicaid or are supported by Medicaid. Examples include: HIPAA and reimbursement for services delivered via interactive video technology. As the

business plan continues to develop and the work around these and other issues progresses, the business plan will be adjusted to incorporate specific work activities related to each.

B. Shared Values

It is imperative that ODADAS, ODMH and the local boards have shared values when it comes to the administration and management of the community Medicaid behavioral health program. These shared values include:

1. The community Medicaid behavioral health program shall be administered in compliance with all federal Medicaid requirements.
2. The community Medicaid behavioral health program should be a system of quality with accountability at all levels.
3. Boards, in conjunction with the Departments, have the responsibility to administer the community Medicaid behavioral health program in a cost-effective manner within a system accountable to multiple payer sources and consumers eligible for assistance under a variety of plans.
4. The delivery of community Medicaid behavioral health services should be consumer centered and outcome focused.
5. Confidentiality is valued, while promoting coordination and involvement of family members and other significant natural support systems.
6. The community Medicaid behavioral health system should provide the most appropriate services in the least restrictive environment that yields the most positive consumer outcomes. Alcohol and other drug treatment service provision should be based upon the “ODADAS youth protocol for levels of care” and the “ODADAS adult protocol for levels of care”.
7. The concept of recovery should be incorporated into the community Medicaid behavioral health program.
8. The community Medicaid behavioral Health program should operate under a community support program model and, as part of this, be integrated with and coordinated with broader, more comprehensive local systems-of-care.

C. Goals and Objectives

While the overall goal of this business plan is to present a unified vision for how ODADAS, ODMH and local boards can improve the administration and management of the community Medicaid behavioral health program, the following objectives are set forth as a methods for achieving this goal.

1. Design and implement a workable local authority model with Medicaid as a major payer.
2. Define the intersection of need for Medicaid compliance without losing local flexibility.

3. Develop uniform cost reporting, rate setting, compliance and auditing rules for the community Medicaid behavioral health program.
4. Establish a statewide clinical system improvement plan.
5. Work collaboratively to establish quality and consumer protection standards.
6. Present a clear message to ODJFS and other constituency groups regarding ODADAS, ODMH and local board Vision for the community Medicaid behavioral health program.

D. Description of Service Delivery Structure

The description of the service delivery structure is broken down into eight categories. These categories include: federal Medicaid requirements; contracting; disputes; auditing and compliance; reimbursement system; claims processing; clinical system improvement; and client protections/consumer/family member participation. Each category is described separately and includes clarification of the role of ODADAS, ODMH and local boards. It is a common understanding that ODJFS, in its capacity as the single state agency, has an oversight and monitoring role in each of the components.

I. Federal and State Medicaid Requirements

The community Medicaid behavioral Health program shall be administered in compliance with all federal Medicaid requirements. As the single state agency, ODJFS is directly responsible to the federal government for all aspects of subrecipient responsibilities. As the subrecipient of ODJFS, ODADAS, ODMH as well as their subrecipients, local boards, each have a responsibility for assuring the community Medicaid behavioral health program is in compliance with the federal Medicaid requirements. See Attachment 1 for a list of applicable federal Medicaid requirements. The community Medicaid behavioral health program must also be in compliance with the Ohio Revised Code and applicable Ohio Administrative Code rules.

II. Contracting

ODADAS/ODMH Responsibilities:

1. ODADAS and ODMH will initiate subrecipient agreements with local boards for the local management of the community Medicaid behavioral health program.
2. ODADAS and ODMH will develop and monitor a standardized Medicaid payment contract for Medicaid reimbursement for both boards and providers.
3. ODADAS and ODMH will assure that providers rendering services have a current ODJFS Medicaid Provider Agreement and current ODADAS treatment program certification and/or ODADAS licensure to conduct a methadone program and/or ODMH certification to deliver services.

Board Responsibilities:

1. Boards have the responsibility to enter into standardized Medicaid payment contracts with any ODADAS-certified/licensed treatment program for any Medicaid covered services it provides and/or ODMH certified provider for the specific services the provider is certified to provide.
2. Boards are responsible for acknowledging, by making payments based upon remittance information produced from MACSIS, a standardized Medicaid payment agreement that has been signed by an ODADAS-certified/licensed treatment program for any Medicaid covered services it provides and/or ODMH-certified provider with another ADAMHS/ADAS/CMHS board if services are provided to a resident of their board area.
3. No ODADAS-certified/licensed treatment program for any Medicaid covered services it provides and/or ODMH certified agency will be denied a standardized Medicaid payment contract.
4. Boards shall perform administrative functions related to rate submission to MACSIS such as reviewing and forwarding unit rates to ODADAS or ODMH for entry into the MACSIS system.

III. Disputes

Boards have limited administrative responsibilities related to resolving Medicaid disputes. However, it is critical that local boards consult with ODADAS and/or ODMH when working with providers to resolve disputes.

ODADAS and/or ODMH Responsibilities:

1. ODADAS and/or ODMH will make determinations in Medicaid disputes related to the standardized payment agreement.
2. ODADAS and/or ODMH will make determinations in the event of Medicaid rate-setting issues.
3. ODADAS and/or ODMH will review instances where provider costs are not within specified parameters and make determinations.
4. All disputes related to the final fiscal audit and/or the termination of the standardized Medicaid payment agreement is subject to the RC Chapter 119 appeals process. The decision to move forward on such appeals will be made by ODJFS and ODADAS and/or ODMH. The process will be initiated by ODADAS and/or ODMH and lead by ODJFS.
5. ODADAS and/or ODMH shall notify the boards of any Medicaid dispute submitted by a provider and include the resolution of the dispute and any required action steps.

Board Responsibilities:

1. Direct agencies to forward disputes related to Medicaid to ODADAS and/or ODMH.
2. Cooperate with all dispute resolution processes.

IV. Auditing and Compliance

Auditing and compliance functions need to be addressed to clarify authority, roles, policies and procedures related to the various financial, compliance and utilization reviews and appeals procedures. This work will include establishing Ohio Administrative Code defining policies and procedures related to all other required reviews (i.e., compliance, medical necessity documentation review, for cause audits, etc.)

ODADAS and/or ODMH Responsibilities:

1. ODADAS and/or ODMH shall monitor the ADAMHS/ADAS/CMHS boards' performance of required reviews (i.e., compliance, medical necessity documentation reviews, utilization reviews, etc) to assure compliance with federal and state rules and regulations.
2. ODADAS, ODMH and ODJFS shall establish a process and standards for the final audit and its implementation.
3. ODADAS and/or ODMH shall establish a mechanism for monitoring the independent financial and compliance audits of boards and providers.
4. ODADAS and/or ODMH shall conduct, at its discretion, a departmental audit of a provider's cost report.
5. ODADAS and/or ODMH shall, at its discretion, conduct departmental for-cause reviews of boards and providers, assess risk and take corrective actions if warranted.
6. ODADAS and/or ODMH shall develop a tracking system to assure that all required reviews are performed and reviewed by the Departments and that appropriate follow up is performed.

Board Responsibilities:

1. For Medicaid covered mental health treatment services, ADAMHS/CMHS Boards shall perform the required reviews (i.e., compliance, medical necessity documentation reviews, utilization reviews, etc) in accordance with OAC rule 5101:3-27-06.
2. ADAMHS/ADAS/CMHS Boards shall assist ODADAS and/or ODMH with for-cause reviews.

3. ADAMHS/ADAS/CMHS Boards shall assure that all agencies receive an independent financial and compliance audit and assure that all follow up activities and corrective actions are complete.
4. Qualified ADAMHS/ADAS/CMHS boards shall have the authority to carry out the consistent, statewide compliance, utilization review and care management functions in accordance with Ohio Administrative Code and under ODADAS and/or ODMH oversight.

V. Reimbursement System

The current system provides for 100% fee for service reimbursement (FFP and match which includes ODADAS and/or ODMH GRF and local funds), on a retrospective cost basis, to participating programs and/or providers. Medicaid covered services are an “entitlement” for individuals determined eligible for Medicaid by a County Department of Job and Family Services (CDJFS) and are offered without limits. This combination of 100% of provider costs being reimbursed and no limit on the services that must be provided has created the current system that cannot be maintained.

Boards need to be more in the position of a “purchaser” rather than that of a “payor”. As a “payor”, the Board has been viewed in the past as the one who just pays the bill, a check writer. In the future, Boards need to be positioned as and perform as purchasers of certain services; the one who is negotiating for a product on behalf of consumers.

In order for this to occur, the reimbursement system needs to move from paying on a cost basis, to purchasing on a “market basis”. Providers need to view Medicaid in relationship to their product lines to determine how much Medicaid services they can afford to deliver at the current “market rate”. Boards must in turn purchase those services in an appropriate amount to assure there is adequate capacity for a particular service without requiring uncompensated care on the part of ~~the~~ a provider.

In order for providers to be successful in a future Medicaid environment, they will need to focus on costs and efficiencies. They need to be able to identify what it actually costs them to deliver a unit of service. This will provide them with the knowledge necessary to know their future ability to deliver Medicaid services, and in what amount. While a provider needs to focus on “costs”, a purchaser (the Boards), need to focus on “price”. The purchaser needs to balance what “price” they can afford based on the number of persons seeking services and the quantity of the services that need to be purchased with the resources available. The provider needs to determine if they are willing to deliver the service for that “price” given the types of services to be provided, the costs associated with providing the service and the anticipated quantity in relationship to other agency product lines and revenue sources.

This transition will need to be implemented gradually in order to sustain capacity and assure consumer needs are being met. However the goal needs to be market rates. It currently is envisioned that the first step in this process is to go to a provider-specific fixed rate payment methodology. This means each provider agency will have a fixed rate for each service based upon actual, audited costs reported on the uniform cost report. There will be no cost reconciliation of provider-specific fixed rates. Moving the system to a provider-specific fixed

rate payment methodology in and of itself will require an extensive phase-in period beginning with the establishment of a uniform cost reporting mechanism.

A uniform cost report will be established in each Department's OAC regulating certification. It will include definitions of cost categories and allowable and unallowable costs. This will standardize how costs are established and reported. A Medicaid rate setting and reimbursement rule will also be established in each section of ODJFS' OAC regulating Medicaid covered behavioral health services to assure consistency and statewideness across boards and providers. This standardization will help assure that the provider-specific fixed rates that will eventually be established are based on sound, audited and actual costs.

It is proposed that the cost reporting rules be effective for SFY 2005. Providers will submit actual cost data for SFY 2005 within 180 days after the close of that fiscal year. Based upon the SFY 2005 actual cost data, provider-specific fixed rates would then be calculated and loaded into MACSIS for SFY 07 services. Providers would continue to be reimbursed during SFY 06 on the existing budgeted and reconciled costs methodology while the work to establish provider-specific fixed rates occurs.

While moving to a provider-specific fixed rate payment methodology addresses many of the issues related to reimbursement, there may be other strategies that the system will want to consider once the business plan has been implemented.

VI. Clinical System Improvement (See Attachment 2)

In order to continuously improve the clinical services, several components of a clinical monitoring system must exist simultaneously to ensure that the system is focused on providing the best clinical care while at the same time monitoring the quality and quantity of care delivered to individual clients. These components include: utilization review, utilization management and care management.

The terms utilization review, utilization management and care management are often used interchangeably, however there is a significant difference between the scope and purpose of each. A comprehensive clinical monitoring system is comprised of all three elements. See Attachment 2, Clinical System Improvement Diagram.

While it is true that individual providers need to have internal systems (utilization review/utilization management/care management) in place at their level, Boards need to have similar clinical system improvement mechanisms in place that provide oversight "across the continuum" in order to ensure quality services are being purchased. While it is recognized that providers must have mechanisms in place in order to assess the services that are delivered by them as an agency, Boards must also have such mechanisms in place to look at what was delivered by the agency in relationship to the total system on behalf of clients. What is described here is a system at the Board level with oversight by the Departments. It does not replace what is needed at the provider level.

The goal is to have a single system design in terms of elements and requirements in order to assure statewideness and consistency and to achieve compliance with other Federal Medicaid

requirements. The statewide program will be implemented by qualified Boards with oversight provided by the Departments.

This will require each board area to assess the requirements and standards for participation in the clinical system improvement program (utilization review/utilization management/care management) and determine the most cost efficient and effective method of implementation (e.g., at the individual Board level, within a consortium, contracting with an outside vendor, etc).

SCOPE OF UTILIZATION REVIEW

The emphasis of utilization review is on ensuring that services provided meet utilization and medical necessity criteria. In order to do this, reviews are conducted at the agency level and are agency specific. The focus of utilization review, which may include retrospective, concurrent and/or prospective reviews, is on the unnecessary or inappropriate use of services that result in excess payments, assessing the quality and providing for the control of the utilization of services (i.e., on medical necessity and utilization criteria.) Utilization reviews are conducted by the Board at the agency level with oversight by ODADAS and/or ODMH. The purpose is to make sure that services were delivered in the proper amount, duration and intensity to address the consumer's presenting problems. The measure by which this determination is made is to review the services provided against utilization and medical necessity criteria. Both sets of criteria are known to the provider and to the reviewer at all times.

Ohio Administrative Code rule 5101:3-27-06 established the statewide compliance and medical necessity documentation review for Medicaid covered mental health services. A statewide utilization review process will need to be established for Medicaid covered alcohol and other drug treatment services and Medicaid covered mental health services in order to be in compliance with federal Medicaid regulations and support the provider-specific fixed rates payment methodology.

The statewide utilization review process for Medicaid covered alcohol and other drug treatment services will need to be implemented through the filing and enactment of OAC. Throughout the development and ultimate implementation of this utilization review process, it is important to keep with shared value number 5 and 42 CFR, Part 2 pertaining to the confidentiality of alcohol and other drug consumer information and HIPAA requirements relating to data usage.

SCOPE OF UTILIZATION MANAGEMENT

Utilization management addresses wider programmatic and system issues. Utilization management may also include special and targeted reviews for high or low service utilization, and review of specific program or services, identification of service gaps and service outcomes. It also includes process and procedures for handling complaints and grievances by consumers and providers. It is different from utilization review in that utilization review is limited to individual case review.

A statewide utilization management process (which could be a refining/redefining of the utilization review processes) for Medicaid covered behavioral health services will need to be implemented through the filing and enactment of OAC. Throughout the development and ultimate implementation of this utilization management process, it is important to keep with

shared value number 5 and 42 CFR, Part 2 pertaining to the confidentiality of alcohol and other drug consumer information HIPAA requirements relating to data usage.

SCOPE OF CARE MANAGEMENT

Care management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet consumers' health needs, using available resources to promote quality, cost-effective outcomes. This occurs across a continuum of care, addressing ongoing needs, rather than being restricted to a single practice setting. The goal is to focus on what can be done to improve the clinical services available to consumers.

IMPLEMENTATION OF UTILIZATION REVIEW

The envisioned utilization review system is focused on case reviews and medical necessity criteria. Individual providers should have internal review processes within their agency. Boards need only to look at "sample" cases to ensure reviews are being conducted appropriately and to take action only in situations where there are problems.

Similarly, the state will need to have a process whereby they are monitoring what the Boards are doing in relationship to reviews. This includes the development of Board qualifications for conducting the reviews, specific review procedures and the appropriate oversight mechanisms and authorities. Case reviews are structured like a pyramid with the broadest number of reviews happening on an ongoing basis at the agency level; fewer reviews at the Board level; and monitoring reviews done at the state level.

It is only in reviewing a sample of cases that a reviewer can identify if there are patterns in the application of the review criteria. In areas where patterns emerge, such as identification of a single clinician consistently failing to document medical necessity or a particular service that is provided where documentation is lacking, a corrective action plan can be required. The general consequences for non-compliance with meeting the medical necessity criteria is denial of payment for any new claims and reversal and repayment of the claims submitted and paid for the period of time in which the clinician's documentation fails to demonstrate meeting medical necessity criteria (i.e., denial of ineligible claims). Additional consequences may apply when indicated.

In severe situations, an agency may be required to obtain prior authorization before delivering services to ensure the ongoing meeting of medical necessity. This would be a time-limited approach to correcting the problems identified. The goal is to maintain reviews as a retrospective process at the agency level.

It must also be clarified that utilization review is inclusive of retrospective and concurrent reviews. Prospective reviews may occur in instances when prior authorization is necessary as a result of previous utilization review findings. It is recommended, however, that the system phase in review types, initially conducting only retrospective reviews and then moving into conducting concurrent and prospective reviews as indicated. Please refer to the attached implementation plan for the proposed phase-in approach.

Ideally, utilization and medical necessity criteria should be established by level of care, indicating criteria for each level, the services to be delivered and a cost threshold. Medical necessity criteria, in and of itself, is not enough to determine appropriate duration and intensity of services. It is necessary to develop utilization criteria (i.e., admission, discharge and continued stay criteria) to conduct accurate reviews. The attached work plan outlines an incremental approach to implementing a level of care system for Ohio.

The utilization review process would be carried out in the following manner.

1. Boards would carry out retrospective ~~case~~ utilization reviews using a random sample case selection methodology developed in conjunction with ODADAS and ODMH and established in OAC. A statewide methodology will be employed for selection of cases to be reviewed. In addition to the agreed-upon statewide method for case selection, a standardized utilization/medical necessity review form will be developed as well as a frequency established for conducting case reviews. This will ensure that all parties involved in the reviews have access and are aware of the “rules of the game”. Regardless of format, the major component of the review would be focused on the provider’s ability to meet utilization and medical necessity criteria at an individual case level.
2. Based on the results of the case review, a number of action steps could be taken. These action steps will be consistent statewide. The action steps need to be on a continuum beginning with training and technical assistance and ending with the most severe consequence of prior authorization of services for a limited period of time; to ensure that the corrective actions have been completed.

For example, after conducting a utilization review, it may be evident that there is a provider training issue, or errors may be associated with a single staff person or a single service that is provided by the agency. In any case, the action steps for the findings needs to match the severity of the findings. A corrective action plan would be developed between the provider and the Board for any findings beyond the established thresholds. A method for monitoring the corrective action plan would be put in place as well as established consequences for not completing the corrective action plan.

As a result of the findings from a utilization review, the involvement of the Board in terms of intrusiveness into clinical care could vary according to the results of the case reviews but within established statewide parameters. Any provider could be subject to prior authorization for any service for any population if the results of utilization ~~case~~ reviews have demonstrated a need for such severe action. The period of prior authorization would be dependent on the severity of the findings. This type of design provides for closer oversight of the poor performers and/or the high-end utilizers of services while maintaining regular retrospective reviews of the best performers.

3. The case selection methodology for mental health services would move from initially being based on cost and/or service thresholds (intensity and service mix) to levels of care, sorting individuals into benefits groups. This cannot be done initially, as there is no current framework for establishing levels of care and/or recommended lengths of service or target costs associated with treatment. The intent is to establish such a system.

The establishment of this is incremental. By using BH Module and ODMH's Outcomes (specifically the ADL scale) information, the system will be able to identify key variables related to the cost and patterns of use. (Housing is just an example of such an indicator.) It is proposed that the collection of BH Module and ODMH's Outcomes information be used to further tailor the sampling methodology to be implemented in FY'05.

The final step to ensuring the most accurate selection of cases to be reviewed is to establish a level of care system. The combination of cost, diagnosis, key variables from the BH Module and the ADL score would allow the system to appropriately place individuals into levels of care. Benefit packages can then be developed from the level of care and cost estimates. As a result, thresholds can be established for services and cost and can be monitored via the utilization review process.

ODADAS has the "ODADAS Youth Protocol for Levels of Care, (Revised Edition)", March 2002 and the "ODADAS Adult Protocol for Levels of Care", April 2002. All ODADAS-certified programs are expected to utilize these two instruments. As such, the development of a utilization review case selection methodology for alcohol and other drug treatment services can begin with the existing levels of care protocols and build upon them. One of the major tasks to be accomplished will be to file the existing protocols in ODADAS' OAC regarding program certification.

4. In addition to the regular oversight provided by conducting case reviews, a threshold (level of care) would be established for each benefit group. The threshold could be based on financial information, quantity of services, length of service, severity of the client served or some combination. The intent is to establish a threshold and any provider delivering services within that threshold would only be subject to periodic retrospective reviews in accordance with established protocols.

If a client were to exceed the established threshold, then the provider would be required to seek prior authorization from the Board. This would allow providers to deliver services in the manner they think is most clinically appropriate up to an established threshold. At that point, the Board would become involved in the decision-making to assure that the best clinical care is obtained across the continuum of services and providers.

By establishing statewide thresholds of acceptability, this focuses a Board's time and resources on those situations which are "high end" and keeps all Boards from having to monitor the day-to-day delivery of services (except through the randomly sampled retrospective reviews previously described).

It should be pointed out that Boards may likely want to continue to prior authorize non-Medicaid covered services, irrespective of benefit group and thresholds, given statutory authority and other funding sources that may be available. Furthermore, this does not erode those authorization functions currently in statute including: prescreening and authorization of all admission to state hospitals, designation and approval of treatment programs for persons committed to the board; assurance of the availability of CSP services to all SMD persons residing in the Board's service district; authorization of admission to adult care facilities; and participation in joint authorization of children with multiple system needs in conjunction with other children's systems.)

5. A system of reporting results of the utilization review system to the state would be developed in order to identify statewide system issues that should be addressed for quality improvement.
6. A statewide method for monitoring the implementation of the utilization review system at the Board level would be put in place at the state level to assure statewide application, compliance with Federal Medicaid requirements as well as compliance with ODMH-required utilization review qualification standards.

IMPLEMENTATION OF UTILIZATION MANAGEMENT

Utilization management includes targeted reviews with the intent of reviewing a specific program or service by individual service provider or across multiple providers to identify areas for improvement. The targeted reviews are generally triggered as a result of identification of unusually high or low service utilization or some other pattern that has emerged from reviewing aggregate data.

Reviews are conducted for the purpose of improving clinical services. There is not a requirement for the frequency of the reviews; rather the reviews are conducted as a result of an identified pattern needing further evaluation.

Also included under utilization management is the handling of complaints and grievances by consumers and families. A targeted review is conducted in order to resolve the complaint or grievance. Reviews are conducted at the time the complaint or grievance is filed and in accordance with established procedures.

IMPLEMENTATION OF CARE MANAGEMENT

Care management is focused on ensuring the integrity of the clinical services delivered to a client, regardless of the number of providers involved. The goal of care management is to continue to clinically improve the system. The focus is on a clinical continuum of care; clinical outcomes; comparability; accessibility; use of best practices and customer satisfaction. Boards and providers both have care management responsibilities.

As investors and payers of clinical services, Boards need to ensure comparability of clinical interventions, irrespective of which provider delivers the services. An individual with a particular diagnosis, level of functioning and similar community supports should expect similar interventions and service intensity irrespective of payer source and/or provider.

The goal of a good care management system is to establish target changes in behavior (clinical outcomes); access standards; satisfaction scores, use of best practices etc. The focus is on developing a “clinical profile” of the package of services that should be delivered based on the presenting problem, not on the individual service delivered.

Collaboratively, the Boards and ODMH will need to continue to develop the care management system as more and more information is available in the BH Module and the Outcomes system. Work being done in this area will directly impact the development of the level of care system.

VII. Claims Processing

ODADAS and ODMH shall enter Medicaid unit rates into MACSIS. All claims for Medicaid services, delivered by certified providers, must be processed through MACSIS and in accordance with the statewide rules and regulations governing MACSIS.

Local ADAMH/ADAS/CMH boards are responsible for paying Medicaid claims at 100% of the net amount as adjudicated in MACSIS. Boards will subsequently be reimbursed the appropriate amount of FFP for all Medicaid services as adjudicated by ODJFS' MMIS system.

Claims must be submitted in a timely fashion in order to assure adequate cash flow to agencies and boards and to support the need for timely, accurate data. It is recommended that providers submit claims within 180 days of the date of service beginning with services provided in SFY '05.

The sections of the MACSIS guidelines that are of a policy nature and have statewide implications will be established in OAC rules.

VIII. Client Protections/Consumer/Family Member Participation

In order to be an eligible provider in the Medicaid program, a provider must be certified by ODMH and/or ODADAS and have a current ODJFS Medicaid provider agreement. The provider must also have a standardized Medicaid payment agreement with a local ADAMHS/ADAS/CMHS Board in order to receive reimbursement for Medicaid covered services. Client protections and consumer/family member participation is addressed in ODMH's certification standards in Chapter 5122 of the Ohio Administrative Code and ODADAS' certification standards in Chapter 3793 of the Ohio Administrative Code.

E. Medicaid Administrative Claiming

The local Boards would like to seek federal reimbursement for the administration of the community Medicaid program for mental health, alcohol and drug addiction services. The federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the proper and efficient administration of the Medicaid program. It is being recommended that initial administrative claiming be focused on the operation of the MACSIS claims payment system. Additional administrative claiming would later occur as work related to other parts of the business plan is completed and statewide Board standards are implemented. The timeframe for beginning this work is currently being negotiated.

F. Assertive Community Treatment/Intensive Home-Based Services

Ohio's Mental Health Commission, which studied mental health in Ohio and made recommendations for improvement to Governor Taft, found there is a need to improve the quality and effectiveness of community-based services for people who remain institutionalized or who lead disrupted lives in the community due to the lack of effective treatment options. The Commission's findings with respect to

service needs of disabled adults and children align with the *Ohio Access Report* of a few years ago which emphasized the need to develop Assertive Community Treatment (ACT) services. Both ACT and Intensive Home-Based (IHB) services are research-validated services; in fact, the Center for Medicare and Medicaid Services (CMS) has communicated to the states regarding the importance of ACT in Medicaid.

Work is currently going on within ODMH and ODMH-sponsored workgroups to develop an Assertive Community Treatment program and an Intensive Home-Based Service program to be included as Medicaid covered services for adults and children, respectively.

G. Implementation Plan (See Attachment 3)

A structure must be established to support the proposed system redesign, including feedback loops, timelines and responsible parties. The implementation plan should describe the body of work that would need to be done in order to accomplish the contents of the business plan; the implementation plan should map out the timelines of what should be accomplished, and by what method (i.e., rule form, procedure, agreement, etc.) Attachment 3, the Proposed System Redesign Timeline, outlines the major area of work, key work activities under each area, and establishes how the work should be sequenced by state fiscal year.

H. Evaluation Plan

An evaluation plan must be established to monitor and evaluate progress toward completion of goals, objectives and implementation plan activities. The evaluation plan for the Medicaid Business Plan should include, but not be limited to:

1. Indicators of compliance with the federal Medicaid requirements
2. Measures related to administration of the Medicaid program (i.e., standardized contracts, timely claims submission and payment, dispute resolution, etc.)
3. Progress towards implementation of the proposed reimbursement system.
4. Progress towards a statewide utilization review mechanism.
5. Client protection measures such as MUI reports, accreditation reports, etc.

It is recommended that the group assigned to complete the work establish the evaluation plan in accordance the specific implementation plan for each major task as outlined in the System Redesign Timeline.

Attachments 1, 2 and 3 follow.

ATTACHMENT 1 - ANALYSIS OF FEDERAL MEDICAID REQUIREMENTS

REQUIREMENT	SECTION OF FEDERAL LAW	FEDERAL REGULATION	DEFINITION
Statewideness	42 USC §1396a(a)(1)	42 CFR 431.50	Requires that a State plan for medical assistance “shall be in effect in all subdivisions of the state, and if administered by [political subdivisions], be mandatory upon them.” The state plan must be continuously in operation throughout the state.
Freedom of Choice of Provider	42 USC §1396a(23)	42 CFR 431.51	Any individual eligible for Medicaid may obtain Medicaid services from any institution, agency, pharmacy, person or organization that is qualified to furnish the services and willing to furnish them.
Comparability	42 USC §1396a(a)(2) and 42 USC §1396a(a)(10)(B)	42 CFR 440.230 and 42 CFR 440.240	A State plan must specify the amount, duration and scope of each service that it provides for eligible recipients. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 (Required Medicaid Services) to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition. The Medicaid agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. The State plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration and scope than those services available to a medically needy recipient and the plan must provide that the services available to any individual in the categorically needy and/or a covered medical needy group are equal in amount, duration and scope for all recipients within the group.
Reasonable Promptness	42 USC §1396a(a)(8)	42 CFR 435.911 and 42 CFR 435.930	The state agency must determine eligibility for Medicaid within specified time periods and must furnish Medicaid services promptly to recipients without any delay caused by the state agency’s administrative procedures; continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and make arrangements to assist applicants and recipients to get emergency medical care whenever needed, 24 hours a day and seven days a week.

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Single State Medicaid Agency	42 USC §1396a(a)(5)	42 CFR 431.10	A State plan must specify a single State agency established or designated to administer or supervise the administration of the plan. That agency must have legal authority to administer or supervise the administration of the plan and make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan. In order for an agency to qualify as the Medicaid agency, it must not delegate, to other than its own officials, authority to exercise administrative discretion in the administration or supervision of the plan, or issue policies, rules and regulations on program matters. The authority of the Medicaid agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the applications of policies, rules, and regulations issued by the Medicaid agency. In Ohio, the Ohio Department of Job and Family Services is the single State agency. (See R.C. §5111.01)
State matching Funds	42 USC §1396a(a)(2)	42 CFR 433.50 and 42 CFR 433.51 and 42 CFR 433.53	A state must provide matching funds for carrying out the State plan on a basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Generally, <u>public funds</u> may be considered as the State’s share in claiming Federal Financial Participation (FFP) if “the public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP.” The public funds cannot be Federal funds, unless they are Federal funds authorized by Federal law to be used as match for other Federal funds. A State plan must provide that State (as distinguished from local) funds will be used both for medical assistance and administration; state funds will be used to pay at least 40 percent of the non-Federal share of total expenditures under the plan; state and federal funds will be apportioned among the political subdivisions of

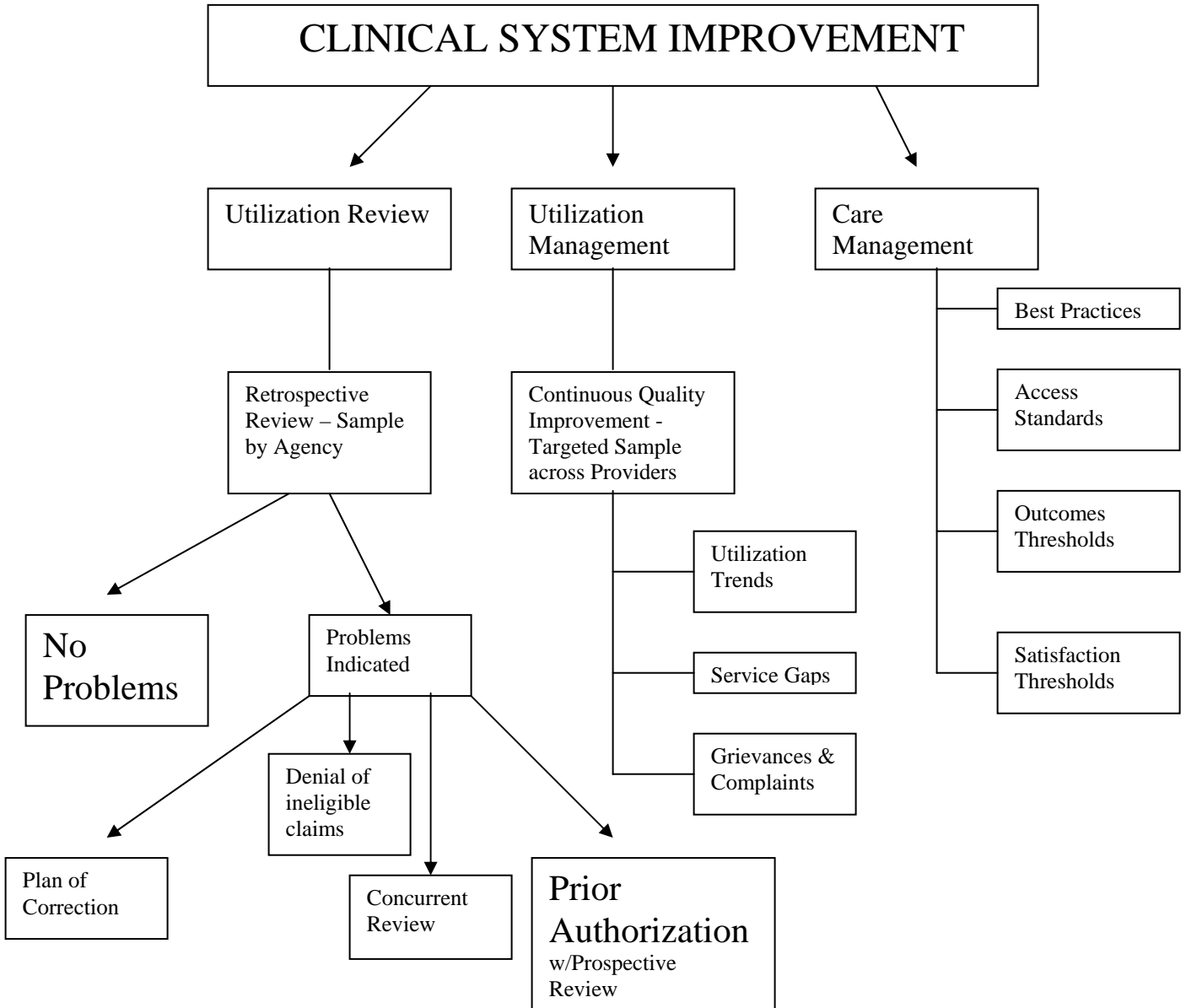
ATTACHMENT 1 - ANALYSIS OF FEDERAL MEDICAID REQUIREMENTS

REQUIREMENT	SECTION OF FEDERAL LAW	FEDERAL REGULATION	DEFINITION
State matching Funds (continued)			the State on a basis that assures that 1) individuals in similar circumstances will be treated similarly throughout the State and 2) if there is local financial participation, lack of funds from local sources will not result in lowering the amount, duration, scope or quality of services or level of administration under the plan in any part of the State.
Out of state	42 USC 1396(a)(16)	42 CFR 431.52	Provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent there from.
Border Issues	42 USC 1396(a)(16)	42 CFR 431.52(b)(4)	A state plan must provide that the state will pay for services furnished in another state to the same extent that it would pay for services furnished within its boundaries if the service are furnished to a recipient who is a resident of the state and it is general practice for recipient in a particular locality to use medical resources in another state.
Utilization review requirements	42 USC 1396(a)(30)	42 CFR 456.3	Provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.
Contracting (Provider Agreement)	42 USC 1396(a)(27)	42 CFR 431.107	Provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.

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Fair Hearing Requirements	42 USC 1396(a)(a)(3)	42 CFR 431.200	Provide for granting on opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon the reasonable promptness.

Attachment 2 – Clinical System Improvement Diagram



Attachment 3 - Proposed System Redesign Timeline (05/22/03)

There are four primary areas that require significant change if the proposed system redesign is to be successful. These four design areas are: utilization management; care management (clinical system improvement); provider-specific fixed-rate reimbursement; and a retooled auditing/compliance structure. The following timeline contains the primary areas of work set forth by SFY. The proposed work is presented incrementally to ensure that the redesign can be completed without the disruption of services and with access to needed data to make informed decisions.

Utilization Review is the first area. It includes retrospective, concurrent and prospective reviews. The focus of utilization review is on the unnecessary or inappropriate use of services and excess payments, assessing the quality and providing for the control of the utilization of services (i.e., on medical necessity and utilization criteria.) Utilization reviews are conducted by the Board at the agency level with oversight by ODMH. Prior authorization (prospective reviews) will be introduced in later fiscal years as a utilization control mechanism when indicated through the utilization review process. Care Management is the second focus area. The focus is on clinical system improvement. The intent of carrying out care management functions is to constantly improve the clinical system; assessing clinical outcomes and ensuring the application of best clinical practices. The third area is provider-specific fixed-rate reimbursement that will move the system away from the current cost-based approach to more of a market-driven system. Finally, auditing and compliance functions are addressed to clarify authority, policies and procedures related to the various financial and compliance reviews and appeals procedures.

(The work related to Assertive Community Treatment (ACT) and Intensive Home-Based (IHB) services is also included in this timeline given it crosses multiple fiscal years.)

SFY '04	SFY '05	SFY '06	SFY '07	SFY '08	FY '09
Utilization Review	Utilization Review	Utilization Review	Utilization Review	Utilization Review	Utilization Review
Establish utilization review and medical necessity criteria for services and/or groups of services for case sampling.	Boards conduct utilization reviews at Medicaid agencies based on established sampling procedures.	Continue utilization reviews using sampling methodology established in FY'05.	Revise sampling methodology to include significant factors reported in BH Module (e.g., arrests, hospitalization) and outcomes (ADL).	Continue utilization reviews using sampling methodology designed in FY'07.	Sampling methodology revised to be based upon established levels of care/benefit packages.

SFY '04	SFY '05	SFY '06	SFY '07	SFY '08	FY '09
Utilization Review	Utilization Review	Utilization Review	Utilization Review	Utilization Review	Utilization Review
Establish random sampling methodology for utilization review based on diagnosis and/or levels of care and utilization (intensity and service mix).	Identify key indicators from BH Module data for inclusion in case sampling methodology.	Boards conduct utilization reviews at Medicaid agencies using established sampling methodology.	Boards conduct utilization reviews at Medicaid agencies using revised sampling methodology.	Boards conduct utilization reviews at Medicaid agencies using established sampling methodology.	Boards conduct utilization reviews at Medicaid agencies using revised sampling methodology.
Establish utilization review procedures.	For mental health consumers, identify key indicators from Outcomes (ADL) for inclusion in case sampling methodology	Test BH Module indicators as part of the criteria for case sampling methodology.			
Identify service pattern groupings for kids.		Test ADL scores from Outcomes for use as part of the criteria for case sampling methodology			
Establish consequences for non-compliance and an agency appeals process.	Consequences for agency non-compliance implemented, including denial of ineligible claims and/or plans of correction	Consequences for agency non-compliance remain the same as SFY '05.	Consequences remain the same for agency non-compliance with the addition of concurrent reviews, when indicated	Consequences for agency non-compliance are expanded to include prior authorization, when indicated.	Full range of consequences exists, including: denial of ineligible claims; plans of correction; and prior authorization when indicated.
Establish Board qualifications to conduct utilization review.	Maintain oversight function by ODADAS/ODMH.	Maintain oversight function by ODADAS/ODMH.	Maintain oversight function by ODADAS/ODMH.	Maintain oversight function by ODADAS/ODMH.	Maintain oversight function by ODADAS/ODMH.
Establish oversight function by ODADAS and ODMH of Boards for utilization review.		Establish procedures and Board qualifications for conducting concurrent reviews.	Establish procedures and Board qualifications for conducting prior authorizations.		
File OAC rules as necessary to support the components of the utilization review process.	File/amend OAC rules as necessary to support the components of the utilization review process.	File/amend OAC rules as necessary to support utilization review process.	File/amend OAC rules as necessary to support the revised Utilization Review process and Prior Authorization.	File/amend OAC rules as necessary to support the components of the utilization review process.	File/amend OAC rules as necessary to support the components of the utilization review process.

SFY '04	SFY '05	SFY '06	SFY '07	SFY '08	FY '09
Care Management	Care Management	Care Management	Care Management	Care Management	Care Management
	Establish standardized reporting from MACSIS data mart including a comparison of Board areas off of UCI and UPI by: -diagnostic categories -outliers -length of stays	Data mart expanded to include ADL info from Outcomes and BH module. Subsequent revision of standardized reporting.	Standardized reporting continues to be revised based on further analysis.	Begin to establish clinical thresholds for BH Module indicators, Outcomes indicators and cost profiles.	Clinical system improvement continues to focus on thresholds for: -comparability -outcomes -application of clinical best practices
		Begin design work on standardized level of care/benefit package.	Continue design work on level of care/benefit package design and linking it to cost.	Test level of care system/benefit package system as method for review and standardized reporting.	Utilization Review linked to LOC/Benefit packages.
Provider-Specific Fixed Rates	Provider-Specific Fixed Rates	Provider-Specific Fixed Rates	Provider-Specific Fixed Rates	Provider-Specific Fixed Rates	Provider-Specific Fixed Rates
Amended 5101:3-27-02 and 5101:3-27-03 with HIPAA changes effective July 1, 2003.	Providers begin collection of cost data for new uniform cost report rule effective July 1, 2004.	Providers must submit the uniform cost report data (180 days after the close of SFY 2005)	Providers reimbursed based on provider-specific fixed rates.	Providers reimbursed based on provider-specific fixed rates	Providers reimbursed based on provider-specific fixed rates
Propose new uniform cost report rule. (2/04) Begin training on the new uniform cost report rule. (5/04)	Interim reimbursement methodology and rules effective July 1, 2004.	Providers reimbursed on the revised budgeted and reconciled methodology.			
Develop interim reimbursement methodology and rules.	Providers reimbursed on the revised budgeted and reconciled methodology.	Calculate provider-specific fixed rates based upon audited uniform cost reports. (2/06-6/06)			

SFY '04	SFY '05	SFY '06	SFY '07	SFY '08	FY '09
Auditing and Compliance	Auditing and Compliance	Auditing and Compliance	Auditing and Compliance	Auditing and Compliance	Auditing and Compliance
Promulgate OAC rule (in 5122) related to the Independent Financial Audit. Revise current ODMH Financial and Compliance Audit Guidelines.	Rules effective January 1, 2005.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.
Promulgate OAC rule (in 5101) related to the Medicaid for-cause review that establishes the process and standards for such a review.	Rules effective January 1, 2005.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.
Amend OAC rule 5101:3-27-06. Review existing protocol to ensure consistency and incorporate sections of protocol into rule as indicated. Establish consistent standards for implementation and incorporate into OAC.	Rules effective January 1, 2005.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.
Begin work related to establishing the process and standards for the Medicaid final audit, its implementation and link to ODJFS 119 appeals process.	Continue work related to establishing the process and standards for the Medicaid final audit, its implementation and link to ODJFS 119 appeals process. Propose OAC rules related to the Medicaid Final Audit.	Rules related to the process and standards for the Medicaid final audit, its implementation and link to the ODJFS 119 appeals process effective.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.

SFY '04	SFY '05	SFY '06	SFY '07	SFY '08	FY '09
MACSIS	MACSIS	MACSIS	MACSIS	MACSIS	MACSIS
Propose OAC rules to assure the consistent statewide implementation of MACSIS. Revise the current Guidelines for the Implementation of MACSIS and other related documents.	Rules effective July 1, 2004.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.	Amend rules as needed based on status of the provider specific-fixed rate, utilization review and care management work.
ACT/IHB Services	ACT/IHB Services	ACT/IHB Services	ACT/IHB Services	ACT/IHB Services	ACT/IHB Services
Propose certification standards in OAC rule for ACT/IHB services.	Certification standards effective.				
Seek federal approval from CMS.	Federal approval effective.				
Amend OAC 5101:3-27 to include ACT/IHB services as Medicaid reimbursable.	Medicaid reimbursement rules effective upon federal approval.				