

**MOU Steering Committee
Finalized Agendas & Minutes
2008 – 2009**

MOU Subgroup Meeting Minutes *January 9, 2008*

Attendees: Don Anderson (ODMH), Angie Bergefurd (ODMH), John Corlett (ODJFS), Doug Day (ODADAS), Erika Robbins (ODJFS), Rick Tully (ODMH), Cheri Walter (OACBHA), Michael Wilson (ODJFS), Hugh Wirtz (OCBHP)

Meeting Convened:

- The meeting opened at 9:00 a.m.
- After subgroup members provided introductions, they began to go over items listed on the agenda
- Goals of the subgroup were discussed. Members expressed a desire to bring about needed changes in the system. They also recognized that the work of the subgroup would provide an opportunity to frame issues that need to be addressed and bigger changes that would need to be made in the future.
- After a short discussion, members decided that the goal of the subgroup is to plan and organize the work for future workgroup members, and that the workgroup members would then recommend how decisions would be carried out.
- It was also suggested that some decisions needed to be made before proceeding, and that the subgroup decide upon recommendations, as well as determine what expertise will be needed to carry them out.
- The subgroup briefly went over the packet from the 9/24/07 MOU meeting for new members.
- Participants discussed the desire to move toward a MITS system rather than following MACSIS. It was agreed that problems exist within MACSIS. Members also mentioned that if and when a move toward MITS happens, there will need to be some serious decisions made regarding how non-Medicaid would work.
- As the flip-chart notes from the 12/21/07 MOU meeting were being discussed, participants recognized two issues that did not appear in the notes - cost reports and link to reconciliation. It was agreed that system finance was a larger parallel issue that would emerge during this work.
- It was further added that current codes for services are too broad and should be narrowed, that a more discreet coding structure is needed. Some members cautioned that this could drive costs, while others expressed that they felt it would ultimately save time and cost.
- It was agreed that system finance reform should be addressed as parallel work. Participants cautioned that this be done without losing sight of the goals of the MOU.
- The subgroup then moved on to address the five work items listed in the flip-chart notes from the 12/21/07 MOU meeting.

MOU Work Items:

1. Medicaid compliance/UR
 - Workgroup goals were established – *see meeting notes*
 - It was agreed that SMI and SED definition would not necessarily be a long term project, and these items were listed as short term goals.
 - Members suggested that the workgroup also recognize long term services. It was decided by the subgroup that nature of services and clinical intensity of mental health services should be considered, and that acute care and AOD services should be accommodated as well.
 - Several participants felt that clinical skills/expertise would be needed to effectively carry out the goals of each workgroup. It was also requested that a limit be placed on the number of people involved, while still providing the expertise needed.
 - A full day workgroup meeting was recommended as a way for members to become entrenched in their goals. Many agreed that intense sessions broken up by breaks, so that members could absorb information, would be the best way to approach the work.
 - It was suggested that the subgroup set up a timeframe for submitting names of those who would be recommended for the workgroups. Members added that it will be important to choose individuals who can remain available for all workgroup meetings and committed to its goals. The subgroup decided that January 25, 2008 would be the deadline for submitting recommendations, as this would be the date of the next MOU steering committee meeting.
 - A policy discussion regarding a moratorium on “06” was recommended. It was decided that this would need to be discussed in the steering committee and not in the subgroup.
2. Monitoring/oversight of Medicaid, including Medicaid contracting
 - Workgroup goals were established – *see meeting notes*
 - The subgroup determined that single state agencies would provide oversight of the departments and that work would continue around the inter-agency agreement
 - The need to talk about delegation first at the steering committee and to explore the impact across all of the work was also recognized.
 - It was cautioned that the workgroup should look carefully at each step and avoid focusing solely on the end result.
 - A question was raised about whether contracting needs to be concerned with the upcoming end of the fiscal year. Members were reminded that the contracts are currently open-ended, so nothing operational needs to happen as they work through the issue.
 - The subgroup decided to wait until delegation/relationships were established before discussing what expertise will be needed for this particular workgroup.
3. Claims Processing/MACSYS guidelines
 - Workgroup goals were established – *see meeting notes*
 - The group will need to look at examples of some work that has already been done in the draft MACSYS guidelines.

- Concern was raised over the fact that providers were not part of this work originally, and members stressed again that they would like to see a movement toward a MITS system, so that claims could be accessed easily to determine their status.
 - The subgroup agreed that this would be short term work.
 - Concern was raised over ODADAS going to web-based technology and reporting in some areas. The subgroup discussed how ODADAS web-based technology for ATR (Access to Recovery) and MACSIS would interface, including having ODADAS IT personnel available to assist if necessary.
4. Auditing requirements (including sub-recipient/vendor issue)
- Concern was expressed over whether audits are truly independent. This concern related primarily to easing the administrative burden that audits cause.
 - Members determined that multiple and confusing auditing requirements is an issue that should be addressed.
 - The subgroup agreed that it only needs to reconstitute the group; that the original group was too large.
5. Non-Medicaid procurement/contracting standards
- Workgroup goals were established – *see meeting notes*
 - It was suggested that this issue could be simplified and set aside if the issue of providers being vendors, not sub-recipients is decided; an independent audit process is established; and the state develops meaningful rules on contract mediation.

Next Steps:

- The subgroup members will present the above discussion on January 25, 2008, at the next MOU steering committee meeting.
- Cheri Walter offered to provide administrative support from OACBHA for one of the workgroups.
- Doug Day will coordinate with ODADAS on the web-based technology for ATR, including consideration on workgroup recommendations.

Meeting adjourned at 11:50 a.m.

MOU Subgroup Meeting Notes

January 9, 2008

<u>XIX Compliance/UR/'06' Goals</u>	<u>Needed Expertise for Workgroup</u>
<p>Clarify & define: “compliance” & “utilization Review” ➤ What does federal law require?</p> <p>Determine roles & responsibilities</p> <p>How will the compliance/UR functions get accomplished? ➤ And by whom?</p> <p>Is it an outlier process?</p> <p>Is it a benchmark process?</p> <p>Need to build in recognition of long term nature of services & clinical intensity considerations of MH services.</p> <p>Need to accommodate acute care as well as accommodate AOD services.</p>	<p>Clinical expertise ➤ AOD ➤ MH</p> <p>Federal requirement expertise (ODJFS) ➤ Legal staff ➤ SUR staff</p> <p>Board representative Ohio Council representative</p> <p>Administrative Support</p> <p>ODMH staff – policy ODADAS staff – policy ODJFS staff – policy</p>

Monitoring & Oversight Goals

Continue interagency process

Medicaid contracting

- Need steering committee recommendation to take to EMMA
- Need to talk about delegation & relationships first
- Need to explore impact across all areas of work (e.g. UR, reimbursement, system finance, etc.)
- Nothing operational needs to happen as we work through this issue (contracts are open-ended)

Needed Expertise for Workgroup

Administrative support

Wait until more work is done to decide what other expertise will be needed

<p style="text-align: center;"><u>Claims Processing/MACSYS</u> <u>(guidelines) Goals - Short Term Work</u></p> <p>Review draft MACSYS guidelines</p> <p>Does additional work need to be done in a technical document or administrative code?</p> <p>Capacity to determine claim status at the provider level.</p> <p>Consider relationship with ODADAS ATR (Access to Recovery) project</p>	<p style="text-align: center;"><u>Needed Expertise for Workgroup</u></p> <p>IT expertise</p> <p>Fiscal expertise</p> <ul style="list-style-type: none"> ➤ Boards ➤ Ohio Council <p>ODMH – policy staff ODADAS – policy staff</p> <p>Administrative support</p>
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<p style="text-align: center;"><u>Non-Medicaid Procurement & Contracting</u> <u>Standards Goals</u></p> <p>Focus on independent audits</p> <p>Have state develop rules around state mediation role</p> <ul style="list-style-type: none"> ➤ Need to have review of authority(ies) <p>Deal w/sub-recipient vendor issue</p>	<p style="text-align: center;"><u>Needed Expertise for Workgroup</u></p> <p>ODMH</p> <p>ODADAS</p> <p>Provider</p> <p>Boards</p> <p>Administrative Support</p>
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Larger System Connections

Define benefit packages

- Amount, scope, duration

Define SMI & SED (short term work)

Service code structure

System finance

- Contracting
- Match responsibility

Reimbursement methodology

MITS

- Non-Medicaid implications

Implementing current healthcare technology

Electronic health record

TSIG

System finance

Non-Medicaid procurement

Process Recommendations

Full day kick off

Recommend names for workgroup by 1/25/08

Policy Discussion

Moratorium on “06”

Medicaid contracting

Recommend goals to steering committee

MOU Workgroup Agenda

February 21, 2008

- Review, revise and approve team charters
 - Claims Processing/MACSYS
 - Mediation
 - Behavioral Health System Audit Team
 - Compliance & Utilization Review
- Review draft rules
 - Mediation
 - Data Use
- Systems Transformation Initiative
 - System Financing
 - Technology
 - Workforce
- Next Steps/Action Items
- Next Meeting

**MOU Meeting
February 21, 2008**

Participants: Bill Bierie, Pat Bridgman, Hugh Wirtz, Angela Cornelius, Doug Day, Michael Wilson, Don Anderson, Amy Rohling-McGee, Bill Harper, Rick Tully, Cheri Walter, David Royer, Debbie Nixon-Hughes, Fonda Dawkins, Dan Arnold, John Corlett, Angie Bergefurd

System Transformation Initiative:

A discussion occurred related to the integration of the MOU work with the Systems Transformation Initiative contemplated in TSIG, particularly with those areas of work related to system finance, technology and workforce. The TWG and Leadership group will talk more about strategies and share financial responsibility to do this work.

Transition to Fee Schedule Reimbursement Methodology:

A discussion occurred related to the state departments' desire to transition to a fee schedule reimbursement methodology for providers for July 1, 2008 (SFY 2009). A meeting was scheduled for February 28, 2008 in order to more fully discuss this transition and establish a work effort to assure that rules and state plans are filed timely, rates are set appropriately and that all operational issues are addressed in advance of the transition.

Team Charter Review:

Claims Processing/MACSYS Team:

Concern was expressed that in addition to what is described in the team charter related to assuring MACSYS is compliant with existing federal and state requirements there needs to be language reflecting a need for ODMH and ODADAS to have the regulatory authority to enforce compliance with these requirements as part of the team mission.

It was agreed that the team charter will be modified to reflect this discussion.

Mediation Team:

The team charter was approved as drafted.

Behavioral Health System Audit Team:

In light of the discussion related to moving to a fee schedule reimbursement methodology it was suggested that the team charter include that the team has the authority to review the audit implications of moving to this type of reimbursement.

It was agreed that the team charter will be modified to reflect this discussion.

Compliance & Utilization Review Team:

This team charter was modified in light of the fee schedule reimbursement methodology discussion. There are many long term suggestions and the charter was drafted using a short term approach to support fee schedule implementation and to meet current federal and state Medicaid requirements.

Approval of the team charter was tabled until ODMH, ODADAS and ODJFS have had an opportunity to prepare and present to the steering committee a model based on the current ODJFS SUR process with recommendations for implementation in the behavioral health system. This model will be discussed at the March 25, 2008 meeting.

Review of Draft Rules:

A brief discussion related to the mediation rules and data use rules occurred. The mediation rules will be the purview of the Mediation Team for further review. The data rules have been tabled pending further work related to compliance and utilization review.

Next Steps:

- Steering committee members will forward to Angie Bergefurd by February 29, 2008 the names of those who will be participating on their behalf on the various teams that have been established.
- Team charters will be revised as agreed to by the steering committee and distributed for review.
- Angie Bergefurd will notify FSCO and OACCA of the status of the steering committee work and will invite participation in the workgroups.
- Minutes will be distributed in a timely manner as well as any relevant meeting materials.
- ODMH, ODADAS and ODJFS will develop a model for UR to be discussed at the next steering committee meeting.
- ODJFS will coordinate a MITS presentation for the next meeting.

Next Meeting:

March 25, 2008
1:30 to 4:30
Location TBD

Tentative Agenda: MITS presentation; UR model review; fee schedule reimbursement update; finalize team charters; systems transformation initiative update; use of a facilitator for future meetings.

Future Meetings:

April 25, 2008
9:00 to 12:00
Location TBD

May 21, 2008
1:30 to 4:30
Location TBD

MOU Steering Committee
March 25, 2008
1:30 – 4:30

AGENDA

- MITS Presentation
- Finalize Team Charters
 - Claims Processing/MACSYS Team
 - Mediation Team
 - Behavioral Health System Audit Team
 - Compliance & Utilization Review Team
- Fee schedule reimbursement & system finance update
 - System Finance Principles & Process Team Charter
- Utilization Review Model
- Systems Transformation Initiative update
- Discuss use of a facilitator for future meetings
- Next Steps
- Next Meeting
April 25, 2008
9:00 – 12:00

MOU Steering Committee Minutes March 25, 2008

Present: Sandy Stephenson, Bill Harper, Michael Wilson, Angie Bergefurd, Angela Cornelius, Doug Day, Rick Tully, Hugh Wirtz, Dalon Myricks, Cheri Walter, David Royer, Debbie Nixon-Hughes, Don Anderson, Pat Bridgman, Amy Rohling-McGee, John Corlett, Bill Bierie, Fonda Dawkins.

Minutes from the February 21, 2008 meeting were approved.

MITS Presentation

- Jerry McKee gave an overview of MITS and the project timeline.
- It was agreed that follow-ups should occur to discuss ongoing progress and how MITS will add value to the behavioral health system.

Team Charters

- Behavioral Health System Audit Team – charter approved. (Angie)
- Compliance & Utilization Review Team – charter approved with revision. (Angie)
- Claims Processing/MACSYS – charter approved. (Doug)
- Mediation Team – charter approved. (Doug)
- Groups can now be convened and start working. Doug or Angie will contact members and arrange initial team meetings.

Fee Schedule Reimbursement & System Finance Update:

- The small fee schedule group met a week ago and made adjustments to rules. The rules are being placed in ODJFS clearance today where they will be for a couple weeks in order to receive feedback. We will still be able to make adjustments while in clearance and throughout the public process.
- CMS will be engaged soon.
- The effect of the fee schedule and match issue have been discussed by both departments and resource allocation on a state level to pay for Medicaid match. Adjustments to the allocations will need to be made for both departments.
- It was suggested to create a team of people to look at the process of allocations across departments.
- Due to the nature of discussions around fee schedules & system financing, it was agreed by all to convene a small group of four or five people outside of this group within the next week to come up with an approach for SFY 2009.
- ODMH will revise their spreadsheets to reflect OACBHA's comments and emailed to the MOU Group.

System Finance Principles & Process Team Charter

- It was agreed that additional members need to be added.
- Send names to Angie by Monday, March 31st.
- Angie will contact constituent groups with consumer/family groups not currently included.
- It was agreed to add no more than four representatives per organization.
- If there is an imbalance noted you will be notified.

Utilization Review Model:

- It was agreed to create an oversight body made up of boards, providers, consumers, and family members to keep the process moving.

Tabled to Next Meeting:

- Systems Transformation Initiative Update
- Use of a Facilitator at Future Meetings

Next Meeting:

April 25, 2008

9:00 to 12:00

Room 806 – Rhodes Tower

MOU Steering Committee Meeting
April 25, 2008
9:00 – 12:00

AGENDA

- Review and Approval of March 25, 2008 Minutes
- Update on Medicaid Reimbursement Rules
 - Clearance Comments & Response
 - Public Hearing – May 21, 2008
 - JCARR Hearing – June 2, 2008
 - CMS Discussions Update
- Review Analysis of Fee Schedule Impact
- Update on Utilization Review – Small Group Discussion
- Update on Meeting with Consumer Advocacy Groups
 - Letter from Directors with Talking Points
- Update on the Certified Public Expenditure (CPE) Process
- Systems Transformation Initiative Update
- Use of a Facilitator at Future Meetings
- Next Steps
- Next Meeting
 - May 21, 2008
 - 1:30 – 4:30
 - Room 1865 – Rhodes Tower

MOU Steering Committee Meeting
April 25, 2008
9:00 – 12:00

Present: Sandy Stephenson, Angie Bergefurd, Fonda Dawkins, Cheri Walter, David Royer, Cristal Thomas, Jim Mauro, Dalon Myricks, Maureen Corcoran, Hugh Wirtz, Bill Harper, Don Anderson, Doug DeVoe, Carrol Hernandez, Sharon Tention, Dan Arnold, Doug Day, Michael Wilson, Pat Bridgman, Amy Rohling McGee, John Corlett, Bill Bierie.

Review and Approval of March 25, 2008 minutes:

- Minutes were approved.

Certified Public Expenditure CPE Process:

- ODADAS, ODJFS & ODMH are preparing a letter to go out asking for participants for a workgroup to further develop this process.
- A web based process is envisioned.
- Several technical issues were raised by steering committee members and will be referred to the CPE workgroup for consideration and resolution.
- Updates will be provided to this group on an on-going basis.

Update on Medicaid Reimbursement Rules

- Public hearing is May 21, 2008.
- JCARR Hearing is June 2, 2008.
- The clearance comment response letter was provided.

CMS Discussions Update:

- ODJFS had an initial call with CMS on April 10th – there is interest in moving to a fee schedule reimbursement methodology.
- Another call is scheduled for May 6th.
- Staff from sister agencies will be present on this call.

Review Analysis of Fee Schedule Impact:

- See handouts that were provided.
- Reviewed the Summary of Statewide Impact of Moving to Fee Schedule.
- Reviewed and discussed the analysis performed by ODADAS, ODJFS and ODMH.

Update on Utilization Review – Small Group Discussion:

- Provided a summary of the small group discussion and recommended next steps.
 - Need to look at baseline data.

- Peer grouping recommendation – providers need to feel comfortable with the peer grouping approach.
 - Provider training needed.
 - UR group will be inclusive and looking at additional members.
 - UR will go into effect in about six months for reviews based on fee schedule reimbursement.
 - Boards need to be able to look at all consumers who receive non-Medicaid, board-funded services.
 - Need to determine the capacity for boards to refer into the SUR process.
 - Need to determine how boards can be kept in the communication loop.
 - Need to assure that while outliers are being looked at there is a check and balance around program standards and compliance for the entire system.
 - Need to make sure there is a mechanism for ongoing monitoring and adjusting of the process.
- See handout – Board Referral Processes Regarding Medicaid Surveillance and UR for ODMH and ODADAS.
 - ODMH/ODADAS certification will be consulted around certification standards, etc.
 - Consensus that Compliance & UR team can be convened – Angie will schedule.

Update on Meeting with Consumer Advocacy Groups – Letter from Directors with Talking Points:

- A summary was provided of the meeting with consumer advocacy groups held on April 18, 2008.

Systems Transformation Initiative Update:

- ODADAS & ODMH will convene the Systems Finance Principles & Process team in near future including consumer/family members.
- There are a number of issues both financial and non-financial that will need to be brought forward to the group.

Use of a Facilitator at Future Meetings:

- This agenda item has been carried forward from the last several meetings.
- The use of a facilitator is a possibility for the Systems Finance meeting and the UR group, but it was agreed that there is no need for a facilitator at the MOU meetings.

Next Steps:

- Convene the chartered teams.

Next Meeting:

May 21, 2008

1:30 – 4:30

Room 1865 – Rhodes Tower

MOU Steering Committee Meeting
May 21, 2008
1:30 – 4:30

AGENDA

- Review and Approval of April 25, 2008 Minutes
- Importance of Consumer & Advocacy Group Participation
- Update on Medicaid Reimbursement Rules
 - Public Hearing – May 21, 2008
 - JCARR Hearing – June 2, 2008
 - CMS Discussions Update
- Update on the Compliance & Utilization Review Team
- Update on the Certified Public Expenditure (CPE) Process
- Systems Transformation Initiative Update
- Next Steps
- Establish Future Meeting Dates

MOU Steering Committee Meeting Minutes
May 21, 2008
1:30 p.m. – 4:00 p.m.

Attendees: Sandy Stephenson, Debbie Nixon-Hughes, Angie Bergefurd, Rick Tully, Jody Demo-Hodgins, Fonda Dawkins, Cheri Walter, Cristal Thomas, Jim Mauro, Hugh Wirtz, Bill Harper, Dan Arnold, Doug Day, Michael Wilson, Bill Bierie

Review and Approval of April 25, 2008 minutes:

- Minutes were approved

Importance of Consumer & Advocacy Group Participation:

- Jim Mauro and Angie Bergefurd will talk at some point after today's meeting to discuss how to ensure that both consumers and advocacy groups are a part of MOU committee work.

Update on Medicaid Reimbursement Rules:

- Public Hearing – May 21, 2008 – Boards expressed concern about moving to fee schedule resulting in the use of non-Medicaid dollars to pay for Medicaid costs, and the need for more information about CPE/UR.
- JCARR Hearing is scheduled for June 2, 2008
- CMS Discussions Update – It was stated that CMS supports the idea of Ohio moving to a fee schedule system and strengthening the role of the state, but that the challenge will be in timing. It was emphasized that the group will need to continue to work on the fee schedule, maintaining it with CMS. It was also stated that during conferences with CMS, they were clear that their main issue of concern is with the coverage section of the state plan. Although the reimbursement piece of the plan was submitted first, CMS is most concerned with the coverage portion. They want to make sure that services are meeting federal requirements and that there are adequate descriptions of the services and who is providing them. The general concern is with rehab option and targeted case management. Concern was raised that blended (bundled) rates would cause costs to go up.

Committee members also mentioned that they heard that CMS has informed states that they have looked at each state plan and identified those that are not compliant with the interim rule (these include Ohio's plan) and are going to notify these states that they must be compliant by 6/1/08. A conference call will take place tomorrow to clarify this information.

The question of whether the approach taken by CMS would change with the election was raised. It was emphasized that the committee's main goal should be to improve stability in the provider system, determining what can and cannot be done now. A committee member said that SAMSHA has recently encouraged

ODMH to look at other Medicaid models that would include rehab option. ODMH will need another week to contact CMS and to have internal discussions in order to make decisions about action that can be taken at this time.

Update on Compliance & Utilization Review Team:

- The team met formally on May 9, 2008. They reviewed the team charter; no changes were made. The team also went through the ODJFS UR model and walked through a straw man proposal.

They decided to allow providers to convene and make recommendations on the peer groups to bring back to the next committee meeting. It was also agreed that a council should form to brainstorm about different ways to ensure quality and make needed adjustments to the peer group. It was stated that meeting federal requirements and ensuring quality care are not always the same. UR team members stated that this group would be looking in an overarching way, not influencing outcomes.

They also talked quite a bit about risk factors in the recent meeting, and are going to take a closer look at them to discuss at next meeting on June 4, 2008. The group would like to do a data extract of 4 years of information before arriving at any conclusions. No new administrative processes will be developed; those already in place should be used.

It was also added that the committee needs to look at ways to help this make more sense to providers, as staff is lost because it is too confusing. It was stated that rescinding the 06 rule and replacing it with the utilization review model would help accomplish this.

The group requested data and reports that ODJFS uses and determined that only provider/ODJFS communications that become public record will be shared with the boards.

Update on Certified Public Expenditure (CPE) Process:

- A CPE process letter was sent out May 19, broadly explaining CPE process. ODADAS has a prototype of the web-based piece and needs technical people from OACBHA to assist. They would like to include staff who do this type of work for both multiple and single boards. Cheri Walter will submit names to ODADAS by May 27, 2008. It was stated that fiscal people should also be involved. The group agreed that once internal discussions have taken place, feedback from key people at the county auditor's office would also be helpful.

System Transformation Initiative Update:

- The System Finance Team will be looking at the model currently in use and principles that are driving it. An external neutral facilitator will be brought into discussions. The group will develop principles and ODMH will take these principles and apply them “to the dollars.” This will need to be a large, representative group, and the work should be done by the end of July. It was decided that this should begin to move forward quickly. Names of those suggested for this team will be submitted to Angie Bergefurd as soon as possible. A letter will be sent out to describe what we are looking for specifically (AoD and mental health will be included).
- A brief survey to boards and providers about their current experience with Ohio scales will be sent out by ODMH. Phone calls are going to be made in a few days to people who are going to be asked to help create this survey.
- Doug Day will be sending e-mails tomorrow to get initial meetings scheduled for MACSIS, Mediation and Audit groups. It has been difficult to align schedules of those involved.

Next Steps:

- Rescind 06 rule – decide what approach will be taken
- Pull system finance group together
- UR group will continue its work
- Audit group will wait to see what happens with reimbursement before moving forward
- MACSIS and Mediation group will get started

Establish Future Meeting Dates:

- June 20, 2008 1:30 p.m.
- July 23, 2008 1:30 p.m.
- August 20, 2008 1:30 p.m.

MOU Steering Committee Meeting
June 20, 2008
1:30 – 4:30

AGENDA

- Review and Approval of May 21, 2008 Minutes
- Update on Medicaid Fee Schedule
- Update on the Compliance & Utilization Review Team
- Update on the Certified Public Expenditure (CPE) Process
- Systems Transformation Initiative Update
- Defining Priority Populations
 Current SMD/SED Definitions
- Next Steps
- Future Meeting Dates
 - July 23, 2008 1:30 p.m.
 - August 20, 2008 1:30 p.m.

MOU Steering Committee Meeting Minutes
June 20, 2008
1:30 p.m. – 4:30 p.m.

Attendees: Don Anderson, Dan Arnold, Angie Bergefurd, Maureen Corcoran, Angela Cornelius Dawson, Fonda Dawkins, Jody Demo-Hodgins, Carrol Hernandez, Debbie Nixon-Hughes, Rudy Rodriguez, Amy Rohling-McGee, Sandy Stephenson, Cristal Thomas, Rick Tully, Cheri Walter, Michael Wilson, Hugh Wirtz

Review and Approval of May 21, 2008 Minutes:

- Minutes were reviewed. Motion to approve was made and seconded.

Update on Medicaid Fee Schedule:

- The committee discussed the 2 recent tri-director letters regarding TBR rules and the ongoing system reform effort.
- It was stated that Directors Jones-Kelley, Stephenson, and Cornelius Dawson, as well as John Corlett, Maureen Corcoran, Angie Bergefurd and Doug Day met on June 6 to discuss fee schedule. A collaborative decision was made to move forward. On June 9, a regional CMS representative was informed that the intention is to keep the SPA active and move forward. In response to an e-mail sent by ODJFS on June 16th, the representative stated that no additional documents would be needed at this time, but that a formal correspondence would be sent to them stating federal requirements with deadlines. Michael Wilson will follow up to make sure that this information is received. He anticipates a response by July 25th. It was stated that after the documentation request is received the 90 day review “clock” will stop.

Compliance and UR Review Team:

- A member reported that the team met on June 4 and talked at length about data exchange between ODMH, ODADAS and ODJFS. It was decided that SFY '04, '05 and '06 would be sent to ODJFS as finalized years (archived from MACSIS), as well as all current information. This will result in 5 years of claims data that can be used for the statistical modeling software. It was also decided that the data will be refreshed monthly. In addition to monthly files, a quarterly provider master file will be sent to keep files current at all times. The group also agreed to data elements that will need to be sent. Since the meeting, ODMH IT programmers have been in contact with ODJFS and are making progress with the file formatting. A question was raised as to whether both agencies (ODMH and ODADAS) are sending this information to ODJFS, and it was stated that ODADAS will not be sending it until the re-disclosure information is implemented in the Interagency Agreement and the revised agreement is signed. It was stated that ODADAS has been present and active in setting up the specifications in the process.

- It was also reported that the team discussed the peer groupings extensively at the June 4 meeting. The recommendation that resulted from this discussion was that instead of taking the initial three groupings, they would like to have four groups – MH kids, MH adults, AoD kids and AoD adults. It was clear that separating kids from adults was very important to team members. The question of whether a dual diagnosis group will be included was asked. It was stated that since these groups would still need to be looked at separately by the two departments, the team decided that it would not be necessary to include a dual diagnosis group. It was also emphasized in the Compliance & UR Team meeting that these peer groupings will not be the only way that data is going to be viewed; this is just the first step in looking at the data.
- The team is also still looking at risk weightings and factors. This is a homework assignment for the next meeting in late July or early August.
- A copy of the draft quality council proposal was distributed to Steering Committee members. This draft was also included in the handouts at the Compliance & UR Team meeting on June 4. It was reported that overall, the Compliance & UR Team's response to the proposal was good. The team members agreed that oversight and quality assurance will be necessary during the UR process. It was stated that language has been inserted into the interagency agreements between ODMH and ODJFS, as well as ODADAS and ODJFS as a way of assuring that the quality council would be responsible for overseeing the process.
- The team is also working on a commitment to be able to share public documents related to the UR process across agencies and with Boards. Only information that is considered public record would be shared with ODADAS, ODMH and the boards. A question was raised in the Steering Committee regarding how it would be decided whether data was a public record. It was stated that ODJFS attorneys will be assisting with these decisions.
- The team is still working through some issues regarding the capacity for boards to directly refer into the ODJFS UR section. The main question is how to memorialize this in the interagency agreement. A standardized process is needed but they are unsure of where it should be documented at this point.
- During a discussion regarding non-Medicaid audits, a committee member stated that a standardized process needs to be developed around clarification of minimum necessary information that can be accessed in these audits. The member stated that this clarification needs to be made for cases in which information is found in a non-Medicaid audit and then referred to SUR or a state department.
- Another issue the team is looking at is how to memorialize the capacity for boards to be able to forward information found in a non-Medicaid review to ODMH and

ODADAS. When boards perform a non-Medicaid review and something is noted that needs to go to SUR, they would like to be able to forward this information to ODMH or ODADAS as well. The team felt that they need a standardized way of triaging this process, but are still working on how they will accomplish this. It was stated that it is difficult to determine how to document the process in a Medicaid agreement, since it is not technically Medicaid-related. A question was raised as to whether this discussion is assuming that the 06 rule is rescinded, and it was stated that this would be the assumption. It was agreed that a process by which departments respond to the boards regarding this issue must be established.

CPE

- It was reported that a web conference took place on June 6. Most of the feedback received was addressed. Another webinar was scheduled for June 27. In this next meeting, the group will be going over processes and next steps regarding training on accessing and utilizing the system.
- The biggest feedback was regarding negative 835s. The concern was that the money may end up in the wrong “pot” in this scenario. This has now been remedied so the “front and back ends” are the same.
- It was emphasized that people need time to transition into this process. A member stated that the team needs to be clear that this is not a new accounting system, but a documentation system. Existing processes still need to be performed, such as documenting how expenses are paid.
- It was also stated that members would like to have auditors present in these discussions to avoid future problems with reimbursement. The concern is that claims will not be certified if reimbursement has not been received yet. Committee members agreed that having a representative from the County Auditors office present in discussions would be helpful.
- It was also stated that providers are very concerned that reimbursement is going to be delayed. A committee member reported that the process itself will not change, with the exception of requiring claims certification; therefore reimbursement would not be delayed unless the certification is delayed. The group discussed possible instances in which this could delay the payment process. It was stated that the webinar next Friday will help work through these issues and that another meeting will also take place on July 2. It was emphasized that reimbursement must not be delayed any further than it already is. Members also mentioned that the MACSIS team will focus on those issues after the Mediation team does more work. A member mentioned that training for providers in the form of a webinar would be helpful. The committee agreed that the FMG group meeting in September would be a good time to provide this training.

System Transformation Initiative

- It was reported that the group met with a facilitator this week and they expect the Finance Principles Team to convene and complete its work in July and August.
- Some discussion took place over whether recommendations for the team have been made. It was stated that names were submitted a few months ago for this team and that feedback would be provided with regard to whether other names need to be added to achieve balance. It was also stated that the group would be approximately 50 people - composed of boards, providers, consumers, family members and state department staff. This group will divide into smaller groups and then reconvene to discuss the principles they have agreed upon. The principles will then be looked at more closely; the group will attach variables to the principles and then the departments will apply these variables to the formulas. A recommendation was made to re-submit the names with the focus on formula, not other system reform issues, in mind. It was decided that the departments would disregard previous names submitted and would send a new request for these names. The recommendations process will be a joint communication between departments.
- It was also reported that work is still being done in EMMA to determine the future of the claims processing system. They are looking at ways to potentially replace MACSIS with MITS. The intent is to have an EMMA-sponsored facilitator look at all departments, describe the “as-is” state and look at it in relation to what MITS can provide. From this, they could determine what gaps exist and what needs to be done to move from MACSIS to MITS without these gaps. A concern was expressed related to whether the new system would include Medicaid and non-Medicaid services. It was stated that the departments have consistently held the position that the new system needs to include both services. Cheri Walter will put out correspondence to let boards know that this issue was raised during the Steering Committee meeting and that the departments are committed to ensuring that Medicaid and non-Medicaid services will be included in the new system. It was also added that until the new process is completely established, we will continue to operate under the MACSIS system.
- It was stated that CET is also looking at provider enrollment, which is not handled by MITS. Their focus is on arriving at a standardized, stream-lined process that aligns with licensure and certification requirements and processes.
- In the area of technology, the group is also focusing on the provider system. They are planning a demonstration project aimed at simplifying documentation requirements. The goal is to facilitate the efficient use of technology and the exchange of electronic health information with other systems. This project is just getting started and is sponsored by TSIG.

- TSIG is also sponsoring a project that is looking at work force issues. The group is considering the enlistment of the Annapolis Coalition to look at these issues within our system.
- With regard to regulatory burden reduction, it was reported that the outcomes process is currently the key area of focus. A recent conference took place between the workgroup and representatives from boards, providers, consumers and family members. This resulted in additional input regarding the development of a survey instrument. Since this meeting, the group has been working internally with that input and will have a draft survey by July 2. The key focus will be getting perspectives on the use of the current outcomes system, particularly focusing on the administration of outcomes instruments, reporting of data and use of outcomes data. The intention is to turn it around very quickly; once they receive input at the July 2 meeting, they will be able to use an automated process to quickly push out a survey and get feedback. The goal is to accomplish this by the end of July or the first week of August.
- ODMH is also working with Synthesis on another project sponsored by TSIG regarding the state wide community of practice based on clusters. The goal of this project is to develop a cluster based approach to utilization management. A question was raised about how the cluster work connects to the UR quality council. It was stated that it would be totally separate from the quality council.
- A committee member also talked about an expedited SSI and Medicaid benefits project in which Franklin and Cuyahoga counties are participating. Tools for the pilot have been developed and it should begin in the first part of July. The Bureau of Disability Determination for Social Security has said that if the proper medical documentation is given, they should be able to give a 15 to 20 day turn-around. This would have an impact on SSI awards and could also be used to trigger Medicaid – greatly reducing the amount of wait time. It was emphasized that this would not apply to all mental impairment, but is aimed at adults with serious and persistent mental illness only. Screening tools would be built in to focus on these individuals who need expedited Medicaid approval. It was stated that this work could potentially be revolutionary for the system and could result in waiting days rather than months for Medicaid.
- Two other current focus areas regarding public entitlements are rollout on the Medicaid buy-in process and provisions around Medicaid buy-in. It was stated that members plan to hold regional forums involving boards, providers and CDJFS people. Their hope is that collaborations would be built that would facilitate quick solutions to inevitable start-up problems. Regarding provisions with Medicaid buy-in, members are looking at ways to change the system in order to allow spend down to cease when recipients return to work, thereby encouraging them to seek employment. It was reported that some issues have been raised regarding whether these changes could violate HIPPA or anti-kick back rules, in cases where an individual is offered employment with his/her mental health provider.

- Suspension v. termination for individuals coming out of institutions is another issue members are working through. This was raised at TWG meeting and a work group is being set up to address it. It was stated that this is a technical issue, not a policy issue. It was also reported that based on the renewed interest, especially on the part of the Governor's office and the Supreme Court, in this issue it is expected that it will be resolved soon.

Defining Priority Populations, Current SMD/SED Definitions

- It was stated that current definitions are not like any other state and are quite confusing. The current SMD definition was said to be particularly confusing around MR/DD. Committee members agreed that cluster defining could help simplify the current definitions. The goal is to better define the more at risk, high need clients. It was also stated that the boards agree that cluster defining is a good idea and would like to be involved. ODMH is just starting internal conversations regarding this but would like input from others. Cheri will inform the boards that this will be happening in the future.

Next Steps

- A Steering Committee member expressed concern over the amount of work that has been completed since the dismissal lawsuit last year. The member feels that not enough outcomes work has been completed and emphasized that Medicaid contract work should be looked at as soon as possible.
- It was recommended that the group go over MOU work to date at the next meeting and possibly generate a report showing the work that has been completed.
- Doug Devoe will not be coming back and Jim Mauro was not present at today's meeting, but the committee had decided in the past that they want to ensure consumer representative participation in this process. The committee agreed that Director Stephenson will invite Janet Galligan from Ohio Advocates to the next meeting.

Future Meeting Dates

- July 23, 2008 1:30 p.m. Rhodes, Room 806A
- August 20, 2008 1:30 p.m. Rhodes, Room 806A

Meeting adjourned at 3:20 p.m.

MOU Steering Committee Meeting
July 23, 2008
1:30 – 4:30

Agenda

- Review and Approval of June 20, 2008 Minutes
- Review of MOU Requirements and Actions Completed
- Update on Medicaid Fee Schedule
- Update on the Compliance & Utilization Review Team
 - Rescinding 5101:3-27-06
- Update on the Mediation Team
- Update on the Certified Public Expenditure Process
- Update on the System Finance Principles & Process Team
- Provider Contracts
- Subrecipient/Vendor Status
- Covered Entity Status
- Next Steps
- Future Meeting Dates
 - August 20, 2008 1:30 p.m.

MOU Steering Committee Meeting Minutes

July 23, 2008

1:30 – 4:30 p.m.

Attendees: Don Anderson, Angie Bergefurd, Bill Bierie, Donna Conley, Maureen Corcoran, Angela Cornelius Dawson, Doug Day, Janet Galligan, Bill Harper, Teresa Lampl, Jim Mauro, Dalon Myricks, Debbie Nixon-Hughes, Amy Rohling-McGee, David Royer, Sandy Stephenson, Sharon Tention, Cristal Thomas, Rick Tully, Cheri Walter, Michael Wilson, Hugh Wirtz

Review and Approval of June 20, 2008 Minutes

Minutes were reviewed and two changes were requested:

- 1) Add discussion that took place during the UR section of the meeting about clarifying minimum necessary information that can be accessed in a non-Medicaid audit when information is found and referred to SUR or a state department.
- 2) It was also requested that the date listed on the first page under the Fee Schedule Update section be changed from June 25 to July 25.

Motion to approve the minutes with these changes was made and seconded.

Consumer Representation

The group's commitment to include consumer representation was discussed. It was expressed that groups other than Ohio Advocates, which has recently collapsed, may want to be involved. It was emphasized that ODMH does not intend to sanction the leader of Ohio Advocates as the representative of all consumers. The group discussed possible consumers who are current service recipients who could be part of the group. Janet Galligan was asked whether she would be comfortable representing consumers and distributing information to them. She stated that she was comfortable with this and it was agreed that more discussion should take place regarding how she would distribute information to consumers. It was emphasized that this information should be disseminated in a neutral way, and should not come directly from Ohio Advocates while the organization is still in transition.

Review of MOU Requirements and Actions Completed

A summary outlining MOU work to date was distributed and discussed. It was stated that committee members seem to be in agreement regarding sub-recipient/vendor status. The general agreement is that providers should be considered vendors and that boards should be considered sub-recipients. A committee member also pointed out that this subject is included today's agenda. It was also stated that although it has not been issued as a statewide statement that providers will be considered vendors, work done so far is pointing in this direction (i.e. fee schedule work). A question was raised that about whether this item refers only to Medicaid, and the answer was yes, this is specific to Medicaid.

The Medicaid contracting issue was also brought up, and it was stressed that this needs immediate attention. It was stated that this is included in a few areas on the summary of work to date and is also an agenda item for today.

Medicaid due process was also discussed. It stated that at the time the MOU was signed, rules related to 5111.914 existed, but that this process had not been used for the collection of overpayments yet. A member stated that ODMH has used this process around reconciliation and has not had problems. It was stated that no issues have been identified which would suggest amendment at this point. A question was also raised about whether the issue of getting match back to boards has been resolved. A member reported that this piece of work has not been finalized, and that the agreement was that dollars would go back to the system from which they came. It was requested and agreed that the boards will be kept up to date on this issue.

With regard to Medicaid compliance and utilization review, it was stated that quite a bit of work has been done, including the straw man proposal, interagency agreement revisions, and creating a legal framework for tracking purposes. It was also added that the Compliance and Utilization Review Team has been meeting on a regular basis and is making progress in developing and implementing a utilization review process for behavioral health services. A team member stated that she felt the outstanding issue now is in deciding the next steps in rescinding the 06 rule. She stated that she believes the group is ready to make a decision about timing at this point, and that this is listed on today's agenda as well.

Work under Medicaid claims processing was also discussed. It was stated that ODADAS is in the process of convening a workgroup for this item. Doug Day will try again to pull together a meeting of this work group next week.

It was stated that substantial progress has been made in revising the interagency agreements to reflect enhanced monitoring and oversight activities. A committee member asked if these revisions have been finalized. It was stated that the revisions were in the final stages of completion. The member also asked if the agreement would be sent out to the committee members and it was agreed that it would be.

With regard to clarifying provider auditing requirements and financial audit consistency, it was stated that ODMH is in the process of convening a work group. Angie Bergefurd is still trying to get auditor participation for this group and will be scheduling a meeting of the work group soon. ODMH has taken this piece of work and shared it with the EMMA Legal and Program Integrity Team, as they are doing similar work. The hope is that the two groups can help each other through this process.

The committee talked briefly about the MOU mutual agreement to use dispute resolution services while performing its work. It was stated that to date, the signatories of the MOU have agreed not to use the services of the Commission on Dispute Resolution and Conflict Management.

Next, the committee discussed the work done around the statewide process for non-Medicaid contracting. It was stated that during the January 2007 meeting of the MOU

Steering Committee, it was agreed that the contracting/procurement issue could be simplified and set aside if the issue of providers being vendors is clarified, an independent audit process is established and the state develops meaningful rules on contract mediation. It was also stated that ODMH is in the process of scheduling the audit team and that the mediation team has been meeting and is working on establishing and amending rules related to alternative dispute resolution. Because these items have been addressed, a member stated that she and other members felt that a separate work group would not be needed for the non-Medicaid contracting issue. A committee member reported that the initial mediation team meeting will result in a deliverable, which will be a revised or new ODMH alternative dispute resolution rule, as well as a corresponding ODADAS rule. The member also reported that legal representatives are working on these rules and will bring their work to the next meeting, which is scheduled for August 11.

A committee member stressed that the work of the mediation team will be extremely important if the group is going to take the procurement issue “off the table.” The member also emphasized that the group needs to move forward and expressed that he felt some of these actions are not really necessarily completed. He is concerned about the overall dismal financial picture across the state.

Update on Medicaid Fee Schedule

A member reported that on July 17, John Corlett of ODJFS received a response from CMS concerning the Amendment to Medicaid state plan to move to fee schedule from a cost based methodology. The response included a request for additional information, and stopped the “90 day clock,” thus protecting the July 1 2008 effective date of implementation with approval. ODJFS now has 90 days to provide the requested information (the deadline is the week of Oct 13). When CMS receives the response from ODJFS, the 90-day timeframe starts again. The requests were reported to be relatively simple. The more substantive requests included:

- Further defining rates paid for service to show that they differ according to type of practitioner
- Reflecting the education level, licensure or certification of the practitioner in definitions of rates
- ODADAS must provide a definition and complete description of each service furnished
- ODMH must define discreet rehabilitation services provided for partial hospitalization
- A list of allowable providers and summary of their qualifications, including education, licensure, certification and requirements for training and supervision must be provided

A member requested a copy of the request and it was agreed that copies would be distributed to the committee. It was reported that the work on the response is in process

currently. A member stated that these requirements mirror what was already requested on May 17, and that some of the work has already begun. A question was raised as to whether ODJFS would be taking the full 90 days to respond. A member expressed that it would be best to submit the response as soon as possible. A discussion followed regarding the challenge in “un-blending” rates for services.

The committee proceeded to discuss how to meet the CMS requirements effectively. A point was raised that CMS may not understand completely how the current system works, based upon requests that they have made. It was stated that an argument could be made that these changes could place additional financial burden upon Medicaid. A member asked whether other states have this kind of rate structure. It was stated that this should be looked at. A member reported that most other states use a fee schedule system and have a broader definition of service. Another member expressed that it would be best not to take the full 90 days to respond to CMS, and that responding to them quickly to see what they ask for next would be the best approach. It was stated that this could all change under a new administration. It was also stated that it would be nice to explore some fallback options as we have control of the timeline now.

A committee member stated that under the current reimbursement system, it is not possible for providers to pay down lines of credit. The member stated that if an opportunity to prepare an argument for CMS presents itself, the Ohio Council would like to be a part of it. A member stated that he and other members are focusing on exactly what CMS is referencing to decide upon the best approach to supporting a fee schedule without creating years of more work.

Update on the Compliance & Utilization Review Team

It was reported that the team has not met since the last meeting of the MOU Steering Committee, but will meet on August 13. A member stated that since the last Compliance & Utilization Review Team meeting, the team has been making progress with the data exchange portion of its work.

The group discussed rescinding the 06 rule, and it was decided that doing so before the October deadline for board financial reports may cause problems. A member expressed that she wanted to assure that clarification was made around the UR rule and that the process is completely codified before the 06 rule is rescinded. Committee members seemed to agree that rescinding 06 should probably be effective no earlier than Nov. 1. Another committee member raised concern over billing without documentation. It was stated that the 06 rule has helped keep providers focusing on documentation. The member stated that when the rule is rescinded, providers need to be motivated in some way to maintain their internal auditing systems. It was further stated that lack of connectedness in billing and documentation is a concern.

A committee member also reported that interagency agreement revisions are almost complete. It was suggested that the work surrounding the rescission of 06 should be a part of the quality council. It was stated that the quality council could find potential problems and provide training to remedy them. A member suggested that 06 be rescinded effective October 31. Many members agreed that some sort of risk management/compliance training needs to be developed before this rule is rescinded, possibly by the quality

council. It was stated that part of the problem with the 06 rule is that providers do not know what findings are and where problems lie. The member stated that having a loop back to a training curriculum would be beneficial. Another member expressed that the group should align its focus on evidence-based practice. The member emphasized that a degree of specificity needs to be reached around the process before the 06 rule is rescinded. It was agreed that specific information regarding this would be distributed before the next Steering Committee meeting. A question was raised about whether waiting until the next meeting would allow enough time to rescind the rule by October 31. It was stated that the information should be ready before the next meeting (within the next two weeks).

Mediation Team

A member reported that the next meeting of the Mediation Team is scheduled for August 11, 10-12. The intention of this meeting is to review what legal staff has drafted regarding dispute resolution.

Update on the Certified Public Expenditure Process

A committee member stated that CPE training sessions are now underway. Six sessions have been scheduled and began last week. It was also reported that good dialogue has occurred, refinement changes have been made to the application, and it is live for July 1st. The member stated that accommodations were made to include 2008 data, since they are entering into a fiscal year, but that so far it is implementing well. With regard to an automation timetable (EDI capability), committee members are looking at ways to standardize funding sources and also focusing on naming conventions. It was reported that boards will need to be looked at separately for this process and capability will depend on the complexity of the individual board's system. Cheri Walter's group is looking at simplifying naming conventions and will submit information to ODADAS tomorrow. ODADAS will move the information through their fiscal department before proceeding to work with each board separately. A question was raised regarding the timetable for EDI capability. It was stated that it would begin after the CPE trainings and that a template would probably be available after the next two months.

System Finance Principles & Process Team

It was reported that the meeting location has changed for the System Finance Principles & Process Team. The meeting will not be held at the Fire Marshall's building but will now take place at the Holiday Inn in Worthington, on Wilson Bridge Road near High Street. A committee member reported that this team will meet on three separate occasions and that a facilitator will be present. In the first meeting, a historical perspective will be given to lay the groundwork necessary for financing the system. After this, the team will be splitting into groups to identify principles. At the August 8th meeting, the team will engage in the process of identifying variables and on August 26th, they will bring everything together, relating the principles to the variables. A member also stated that although some people will not be able to attend, they will have the opportunity to voice their opinions at other times during the course of this work.

Provider Contracts

It was reported that members are working to update the ODJFS three year limited agreement. A member stated that a document should be created for use by boards locally

in working with their auditors. It was stated that before approaching this piece, the committee might need to wait for the outcome of the mediation process. A member expressed that mediation does not involve Medicaid. There was some discussion over whether this is a board or state issue. A member stated that the main issue revolves around the idea that what is being done locally is outside of the federal processes. Problems with Cuyahoga County were discussed briefly. It was stated that in CMS discussions contract issues with local entities have been raised, so these issues should definitely be considered. It was also stated that driving variance out of the system would pose problems in the future. A member asked whether it is still acceptable to the committee to keep this issue alive via state monitoring as well as mediation team work, and to address problems as they occur. It was stated and agreed upon by the group that this is actually not a mediation issue and should therefore not be addressed in this manner. Another member requested a commitment from the state to be involved with this as well as the boards. It was agreed that states will be made aware of problems regarding provider contracts and that boards would also be kept update in these matters.

Sub-recipient/Vendor Status

It was stated that a recommendation around providers being vendors should to be made. A member asked if the committee agrees with viewing providers as vendors and whether the committee wants to ensure that their work reflects this view. The member stated that the committee should come to an agreement on this issue in order to move forward with the audit work. After some discussion, the committee seemed to be in agreement that providers should be considered vendors. The question of whether this needs to be documented in some way was raised, and it was agreed that this could be discussed in the auditing group. A member also asked if providers who are paid from other federal funds (other than sub grants) would still be considered a vendor. It was stated that this focus is specifically on Medicaid funded work.

Covered Entity Status

A member reported that the two departments are continuing to work on this item. The member also reported that Sloan Spalding is leading this project at ODMH. He is trying to resolve this by January.

A question was raised over whether MOU Steering Committee minutes would be made public information. It was stated that this was requested at an ODADAS leadership meeting. A member reported that this was recently discussed during a meeting with the ODMH Web Facilitator and Communications Director. A recommendation was made that the MOU Steering Committee minutes could be posted on the website as public documents. It was stated that charters of workgroups and settlements would also be posted to give people context and background regarding the work.

Next Meeting

The next meeting of the MOU Steering Committee is scheduled for August 20, 2008. It will be held in Rhodes, 8th Floor, Room 806, 1:30 p.m.

Meeting adjourned at 3:30 p.m.

MOU Steering Committee Meeting
August 20, 2008
1:30 – 4:30

Agenda

- Review and Approval of July 23, 2008 Minutes
- Update on Medicaid Fee Schedule
- Update on the Compliance & Utilization Review Team
- Update on the Mediation Team
- Update on the Certified Public Expenditure Process
- Update on the System Finance Principles & Process Team
- Next Steps
 - The Audit Team meets August 25, 2008
- Future Meeting Dates

MOU Steering Committee Meeting Minutes

August 20, 2008

1:30 – 4:30 p.m.

Attendees: Don Anderson, Dan Arnold, Angie Bergefurd, Bill Bierie, Pat Bridgman, Donna Conley, Maureen Corcoran, Fonda Dawkins, Jody Demo-Hodgins, Jodi Elsass-Locker, Bill Harper, Carrol Hernandez, Dalon Myricks, Amy Rohling-McGee, Sandy Stephenson, Rick Tully, Cheri Walter, Michael Wilson, Hugh Wirtz

Review and Approval of July 23, 2008 Minutes

Motion to approve with the following changes was made and seconded:

- Add language under the Provider Contracts section to reflect the conversation in which it was agreed that contracting is not a mediation issue
- Under the Compliance & UR section, document concerns related to rescinding the 06 rule before codifying the process with a high degree of specificity

Update on Medicaid Fee Schedule:

A member reported that revisions to the forms and to the SPA itself (on both the financial and coverage side) which CMS requested have been made. It was also reported that a cover letter has been drafted and that the three state agencies are working together to complete the requests by October 13, which is the 90-day deadline for the response. A member asked for clarification about what CMS has requested. Another member referred the group to the letter from CMS, which had been distributed to the group prior to the meeting.

It was stated that inaccuracies exist in the first bullet of the letter from CMS. This bullet states that Section 1902(a)(32) of the Social Security Act requires that rates are economic and efficient; however, this is not actually stated in this section of the act, but is stated in Section 1902(a)(30). Since it is unclear whether they are referring to Section (a)(32) or Section (a)(30) it was decided that clarification would be requested from CMS in the cover letter that the three agencies are sending. It was stated that if they are referring to Section 1902(a)(30), it could be argued that this has already been done.

A member asked why it was necessary to wait until the cover letter is sent to ask for clarification on this point. Another member stated that originally the strategy was to set up a teleconference with central office staff at CMS. This changed August 11, after speaking with the CMS regional contact person who indicated that this would not be the best approach to addressing this issue. ODJFS staff met on August 13 to discuss alternative approaches, including meeting face to face with some of the essential decision makers at CMS, and it was decided that asking for clarification in the cover letter would be a better strategy. The member emphasized that they are doing what they can to follow the intention of the group to respond as quickly as possible. He stated that the agencies are hoping to send the response to CMS later this week or sometime next week.

It was stated that out of the nine requests that were made by CMS, the agencies have effectively crafted responses to eight. A committee member suggested that the response to CMS include answers addressing the question in both ways – referring to both Section

(a)(32) and Section (a)(30). Another member expressed that the agencies decided not to respond this way because they wanted to avoid opening up more discussion. The other committee member stated that they will already be opening up more discussion by asking for clarification. After some discussion, it was agreed that the group would respond as if they are referring to Section (a)(30), since the words “economic and efficient” are actually only found in this section.

A member also reported that the fee schedule analysis has been updated and that ODMH is in the process of finalizing it. 2008 actuals were about 2% above what the projections were; it was stated that this indicates that future years will be a little higher as well. A member requested that the analysis be distributed to the boards; it was agreed that it would be completed and distributed soon. It was also clarified that the analysis would be done by board.

A member stated that if changing to a fee schedule methodology cannot be achieved quickly the group should return to discussing a rate ceiling increase by named service. A question was raised regarding whether the group may not know anything before 90 days after they respond to the CMS request. It was stated that this could bring them into the end of the year before anything is known, and if this does happen the focus should definitely move toward ceiling discussions.

A member stated that the situation is getting worse rapidly, mentioning that one agency has moved to only providing high priority, emergency services due to financial difficulties. Another member stated that he has heard of layoffs occurring and people leaving their positions because others are offering much higher wages. It was also stated that Medicare will be hit hard as well because providers will not be able to afford to subsidize with it anymore. Members also discussed treatment waiting lists in the criminal justice system. It was stated that this should be considered a priority population.

Another concern was raised regarding how Medicaid dollars are tracked when they are used locally, i.e. juvenile courts and drug courts. A member expressed that what happens when youth either do not have Medicaid eligibility or lose it is unclear. Another member expressed that the CPE process may help to determine what is being pulled from match, whether it is a legal match and the intended use of the dollars.

Update on the Compliance & Utilization Review Team

A team member reported that ODJFS has successfully converted the data file that was sent by ODMH. She stated that ODMH will continue to send this file monthly and that as soon as ODADAS has a signed interagency agreement they will also begin sending their own file. A question was raised about the timeline for this interagency agreement and it was stated that it is very close to completion. It was also stated that ODADAS has been involved with all of the data discussions so far, so the hope is that they will be ready to implement this process as soon as they have the signed agreement.

It was reported that the team is now finalizing the Quality Council document. The member also reported that the Referral Process Document was reviewed by the team per the instruction of the Steering Committee. Quite a bit of discussion regarding this

document took place at the last meeting and team members made many suggestions about details to be added to the process.

The member stated that the team discussed creating a standardized intake form, and whether ODMH/ODADAS or ODJFS would be notified first. The team also discussed whether providers would be notified at the point when the form is submitted, and who would be responsible for notifying them. It was stated in the team meeting that boards may notify the providers of the submission of the intake form and that ODJFS would only notify them in cases where documentation is being request or if an overpayment was made. ODMH/ODADAS would notify the provider if the investigation involved certification violations.

During the discussion about the process that will follow the receipt of an intake form, an issue was raised regarding cases in which suspicion of fraud exist. It was emphasized that this would clearly not be part of the process involving the state agencies; these cases would always be referred to the Attorney General's office. It was also stated that the providers should not be notified in cases where fraud is suspected.

The team member also reported that concern was raised around when providers would be notified about an intake form. It was agreed that it would be best to notify them as soon as possible so that they can begin to correct any problems. She also stated that after the details are added to the process document, it will be brought back to the Steering Committee. She reported that the team also discussed instances in which the board refers cases directly to ODJFS. An ODJFS representative on the team clearly stated at the meeting that these cases will still go through all of the state agencies as well.

It was also reported that the Compliance & Utilization Review Team discussed non-Medicaid reviews. It has been requested that the minimum necessary information that providers are required to give boards in a non-Medicaid review be defined clearly. The team agreed in their last meeting that this was not necessarily a focus on which they should be concentrating. They felt that rules around this are already outlined in existing requirements – i.e. revised code 340 rules. They decided to bring the issue to the Steering Committee to determine who should define the minimum necessary information. The team felt that it would be helpful if someone went through existing requirements to find specific rules that already address this issue.

A member asked why the team decided that they would not be responsible for this work, or at least for attempting to put some boundaries around the issue. The member expressed concern that not addressing it would create an open-ended process similar to the 06 rule. It was stated that the Compliance and Utilization Review Team was also concerned about this and that this is why they decided not to address it without assistance. They felt that they did not have the right expertise to address a non-Medicaid issue. It was suggested that legal staff could provide help.

A member clarified that the concern involved cases in which Medicaid and non-Medicaid are part of the same review. It was stated that something needs to be done to standardize the reviews; that the 06 rule did provide some boundaries by specifically stating that boards were supposed to look at Medicaid data. It was added that this should be

addressed because it could become even worse when 06 is rescinded. A member emphasized again that this is addressed in already existing codes, so it may not be necessary to create an interpretive document but instead find a way to refer to the existing codes. It was agreed that asking legal staff for assistance would be the best approach. It was also stated that boards would benefit from more sophisticated reviews that are efficient but not overly burdensome.

It was also reported that the team discussed the risk assessment in their last meeting and has finally decided upon their approach to this exercise. The exercise is still not finished but they are hoping that it will be completed before the next meeting of the team. More information will be provided to the Steering Committee at this time.

A member reported that the team also discussed the timeframe for rescinding the 06 rule. According to her Steering Committee notes, October 31, 2008 was the agreed-upon rescission date. The Compliance and Utilization Review Team wanted to confirm this date and determine what additional requirements and/or documentation is needed by the boards prior to the rescission. A question was raised regarding when the interagency agreements would be ready to be distributed. It was stated that signatures are still pending. A member stressed the group is definitely moving ahead with rescinding the 06 rule on October 31, therefore issues should be addressed within this timeframe. Another member stated that the boards need to see the interagency agreement before they can be sure that all issues are addressed.

A question was raised regarding whether 2008 compliance review deadlines would go out further than the rescission date. A question was raised about whether the state would be requiring the reviews more than once this year due to the timing of rescinding the 06 rule. It was clarified that these reviews are only required once per fiscal year. The requirement is that 2008 needs to be "closed out" before October 1, 2008. It was suggested that correspondence be sent to boards stating that if they have already done an audit this fiscal year they do not need to do another one before Oct 31. It was agreed that something would be sent out to provide clarification to the boards.

Clarity was requested regarding the peer group recommendations. A member asked whether the recommendations made in the small groups were brought back to the Steering Committee to be used. It was confirmed that they were.

A member stated that the next Compliance and Utilization Review Meeting would take place on September 24.

Update on the Mediation Team

A member stated that the group looked at ODMH and ODADAS draft rules regarding dispute resolution during their second meeting. The group agreed that additional processes in the rule are needed, such as formal dispute resolution in the first thirty days, mediation within the second thirty days and an arbitration phase during the last thirty days. The group intends to clarify these processes, making sure that they are completed before twenty days prior to the termination of the contract, per revised code.

It was stated that the team felt that the biggest issue is that these adjustments can be made as a short term fix; however, the long term approach would involve changing statutes. The group decided that they would do the short term fixes and then come back to the steering committee with recommendations regarding changes in statutes around procurement and dispute resolution improvements.

Another member stated that he agreed with this plan. He expressed concern about the fact that ODADAS does not have rules under current statute. He also stated that he felt that the current statute precludes moving toward a binding decision. He stated that the language in the statutes contains many “mays” rather than “shalls” which does not actually force anything. He also stated that since an administrative process exists, it is difficult to appeal if one of the parties is not satisfied. He added that the team needs to look at whether they want to include binding decisions in the statute changes and if so whether the decisions could be appealed.

Another member stated that the Mediation Team wanted to start by confirming that the Steering Committee is OK with them looking at statute changes, and has not focused on specific statute changes yet. It was stated that the intent is to encourage resolution without going to court. Members expressed that under the current statute the first 60 days is often wasted because there is not enough pressure to resolve dispute within that timeframe.

Update on the CPE Process

A member reported that an update was sent out on August 12. She stated that providers have started to use the process. The member stated that regional training sessions and webinars have also taken place. Twenty-six items of improvement were recommended by the boards. ODADAS and ODMH have addressed all but five of these items. One of the suggestions they received was to add an EDI interface function, and they have scheduled an August 27 meeting to discuss this. A member stated that the boards have appreciated how helpful ODADAS and ODMH have been, stating that she just signed a letter thanking them and bringing up a few more important points to be addressed.

A question was asked about whether the CPE process will also be helpful with the providers’ own year-end audits. It was stated that the process could potentially be helpful in this respect. A member asked if state funds could be claimed by department instead of drilling all the way down to the specific state fund. It was stated that since there are specific restrictions around some of the individual state funds this might not be possible.

A question was also raised regarding whether concerns about delays in provider payments have been addressed. It was stated that the process has not stopped any payments from going through and that problems are not anticipated at this point. It was also added that in the event that this does become a problem, one suggestion was to move to a weekly processing schedule (instead of bi-weekly).

A member asked whether all boards are in the testing phase of the CPE process now. It was stated that it is believed that all of them are. The member also expressed that she would like to set up a meeting in the second week of September to talk about what can be

done to assist those who are still not using the CPE process. It was also suggested that communication be initiated with providers to address any issues or concerns with the new system.

It was also stated that the issue of two year contracting should be addressed. A member stated that moving to a two year process would be extremely helpful, adding that the current system is tied to an outdated process.

Update on System Finance Principles and Process Team

A member reported that the System Finance Principles and Process Team will be meeting 10 a.m. - 4 p.m. on August 26 at Holiday Inn in Worthington. He stated that the group has developed a set of 16 principles, which they also prioritized. At the last meeting, the group focused on the top six principles:

- Uniform access to a core set of services and supports appropriate to the need of the consumer
- Scarce resources prioritized to those most in need
- Maximum dollars to direct services
- Funding supports an economically viable provider system
- Funding supports outcomes which are consumer-centered, effective, high-quality, least restrictive and most appropriate
- Funding supports culturally competent services

It was also reported that the team broke out into groups to begin to take the top six principles and attempt to create variables around them. The resulting work product was a list of issues related to creating variables around those principles. It was stated that although the group did not actually get to the point of creating variables that will operationalize the principles, listing these issues was helpful. This work product has been distributed to the group, and next Tuesday they will focus on developing the variables.

A member asked for an example of a variable. Examples given were prevalence around the SMD population, measure of poverty and per capita. It was stated that some common themes were visible and that the group is now charged with creating variables from these themes. Another member stated that the group discovered that it may be easier to come up with the variables first and then draw connecting lines from them to the principles.

Next Steps

A member reported that the first meeting of the Behavioral Health System Audit Team is scheduled for August 25, and that the MACSIS team is scheduled to meet on September 2. She added that these are the last two groups that needed to get started.

Another member asked when the MITS web portals would be ready. It was stated that the Medicaid claims submission portion is already partially posted. A member reported

that there are several MITS web portals for different types of agencies, and that ODJFS is working with the sister agencies to put together information regarding the portals.

It was also reported that Medicaid eligibility verification will be included in one of the portals. A question was raised about whether the eligibility verification would show whether an individual was eligible and whether the individual is in a managed care plan. It was stated that it is believed that this information will be available under this portal. A member stated that ODJFS is trying to be deliberate in providing the different agencies with the information they need to effectively use these new portals. It was also stated that these portals will be posted in a series of stages.

Future Meeting Dates

The Steering Committee agreed upon the following dates and times for future meetings. Appointments will be sent to members when locations have been confirmed.

9/17: 1:30-4:30

10/15: 1:30 – 4:30

11/19: 1:30 – 4:30

MOU Steering Committee Meeting
October 15, 2008
1:30 – 4:30

Agenda

- Review and Approval of August 20, 2008 Minutes
- Update on Medicaid Fee Schedule
 - Status of CMS RAI Response
- Update on the Compliance & Utilization Review Team
 - Status of the Interagency Agreements
- Update on the Mediation Team
- Update on the MACSIS Team
 - Behavioral Health Operations Committee
- Update on the Audit Team
- Update on the Certified Public Expenditure Process
- Next Steps
- Future Meeting Dates

November 19, 2008
1:30 – 4:30
Room 806A – Rhodes Tower

MOU Steering Committee Minutes
October 15, 2008
1:30 – 4:30 p.m.

Attendees: Don Anderson, Dan Arnold, Angie Bergefurd, Bill Bierie, Pat Bridgman, Maureen Corcoran, Fonda Dawkins, Doug Day, Jody Demo-Hodgins, Nilu Ekanayake, Bill Harper, Carrol Hernandez, Sandy Stephenson, Cristal Thomas, Rick Tully, Cheri Walter, Hugh Wirtz

Review and Approval of August 20, 2008 Minutes

A motion was made and seconded to approve the minutes with the following changes:

- Remove the word “not” in second sentence of first full paragraph on page 4.
- Update the six principles listed under the section titled “Update on System Finance Principles and Process Team” to reflect the principles finalized by the team.

Update on Medicaid Fee Schedule/ Status of CMS RAI Response

An ODMH representative distributed the Summary of Statewide Impact of Moving to Fee Schedule document. She explained that actual numbers were used and extended to the year 2013, with FFP and Match also separated out. It was reported that ODMH was off by approximately +2%, and ODADAS was off by about 1% from estimates to actuals. It was stated that there was an increase in the dollar amount due to increased volume of units. Another committee member stated that as time passes, the ceilings become a natural fee schedule.

It was stated that the real issue in time may be growth, rather than fee schedule, and this is something that needs to be watched. Another member added that the kind of growth that is occurring should be considered; it could be the number of units or the number of eligible consumers that is growing. Several members agreed that it could be both the number of units and the number of eligibles causing the growth.

It was reported that the percent growth was determined based on actuals for '05, '06, '07 and '08. It was clarified that 2.7 million (at bottom of the page) represents the impact on FFP, which required when the State Plan Amendment is submitted. It was further stated that this number was weighted based on SCHIP and Medicaid, and that the numbers are for both AoD and Mental Health. The committee members will go through the documents and bring any questions that may arise back to the committee.

The RAI response was distributed to committee members. This packet contained the following items.

- Cover letter to CMS
- Specific questions CMS asked and responses given
- Standardized transmittal form
- Pages which were amended

It was stated that per the instructions of the committee, the state agencies reconsidered their response to question 1, due to the ambiguity in wording of the question. They

responded in both ways in which the question could be interpreted. The content of the answer was basically unchanged; it states why the state believes that the rates are economic and efficient.

In previous meetings, it was stated that the deadline for the letter was 10/13, and the letter is dated 10/15. A member clarified that the state agencies had originally thought that 10/13 was the deadline, but it is actually 10/15. It was stated that the “90 day clock” for a response from CMS has started now. A member expressed concern over the long amount of time it will take; he stated that the group had said it would try not to stretch this out so far in the beginning. Another member stated that she felt from the beginning that the committee would be working past January 2009. It was also stated that even with an administration change, CMS operations will take some time to get moving in a different direction.

A representative from ODMH asked a board representative where they stand with this issue now, as they were in disagreement previously. The board representative replied that they were waiting for this packet to discuss the issue; they will go back and talk about it now and their position will depend upon the current situation. The ODMH representative stated that the issues the boards had have not changed, except that the provider situation continues to worsen. She stated that if this is going to continue in multiple three month cycles, the only other way to provide relief to providers would be to bump up some of the rate ceilings. She asked if discussion about raising the rate ceilings for specific rates has taken place among board members. A board representative reported that they had discussed ceiling increases with certain rates.

It was stated that it is unclear how long CMS will take to respond; they are very hesitant to give any kind of timeline. A member expressed concern that changes resulting from a new administration would not bring about changes with this very quickly; the “trickle down” would take some time. Members agreed that these changes would not happen immediately after January 20. A member noted that it is possible to move forward with some changes at the state level without having to wait for CMS approval. It was stated that ODMH is looking at all possible regulatory reductions and would welcome any in put.

A member stated that one area in which the time and expense of auditing requirements could be reduced is in the sub-recipient vs. vendor status. He added that audits would be shorter and less expensive for providers who are considered vendors. He emphasized a need for clarification to the field of providers regarding the issue of vendors vs. sub-recipients. It was stated that this topic was discussed during the audit team meeting last week. The group decided to return to this topic later in today’s meeting.

A member stated that one remaining unknown in the RAI response is CMS’ reaction to the ODADAS service definition of case management, whether it fits in the parameters of the new rule. A question was raised regarding whether issues were raised in the context of TCN, and the response was that it was not.

Update on Compliance & Utilization Review Team/Status of the Interagency Agreements

A member reported that the State still plans to rescind the 06 rule on the previously determined date. She further stated that the correspondence providing clarification around how auditing requirements will be affected by this rescission will be sent to the boards today. This correspondence was distributed to the committee. It states that boards will be required to submit 2008 reviews, but should not begin 2009 reviews until the effective rescission date is determined and the State sends out additional information related to the utilization review process.

It was reported that a call received by an ODMH staff member indicated that some board members had convened and decided to continue performing their '09 reviews, because they believed that under the 340 rule they would still have an obligation to do so. ODMH staff looked at this rule and did not come to the same conclusion. The reporting member asked an OACBHA representative whether they could clarify this with the boards. The representative stated that they had already discussed this, and they plan to clarify the issue with the boards; they have no issue with not beginning the 2009 reviews.

An ODJFS representative stated that they have only received a handful of comments regarding the planned rescission of 06, but none were substantive. He further stated that the comment period ended yesterday, and that it will now go through internal processing. A member asked whether the rescission went into clearance; it was reported that it did last week. It was also stated that it still needs to go through public and JCARR hearings. The committee determined that boards and providers were somehow left out of the notification process when this went into clearance. It was stated that in the future the state agencies will ensure that they are included. A member asked when this would go to JCARR and it was reported that they do not know yet.

A Compliance and UR team member reported that they anticipate holding one more meeting. She reported that the team has been monitoring the data exchange and it has been going well. The team has also determined that they are finished with discussions around the quality council; this work is complete, with the exception of determining the schedule for its future meetings. She also reported that the team held a good discussion regarding the board reporting process, and has made adjustments to the process document. This piece will be finalized at the next meeting. ODJFS will be running the data from the risk factor analysis exercise completed by the team members, and is planning to report the results at the next meeting.

Members of the Compliance and UR Team also reported that during the last meeting they discussed resources that already exist on both the Ohio Council and the OACBHA website. These resources outline collaborative work completed a number of years ago by boards and providers which addressed many of the issues currently being discussed around minimum necessary information in non-Medicaid reviews. A member stated that the group felt that these resources were sufficient to address these issues within the scope of the work of the Compliance and UR Team.

Some committee members expressed that they feel the Compliance and UR Team should continue to meet, and that the work of the committee can not be handed off exclusively to

the Quality Council. Other members of the group stated that they believe the work that the team has been asked to do is complete. The committee reached a general agreement that when this final report is given, they will decide whether the team will need to do more, or if the quality council will be able to handle the remaining problems.

A member raised a point that since the needs of consumers are independent of the payer source, using the same model for Medicaid and non-Medicaid would make more sense than separating them. He stated that this would avoid having to create a variation of the system for the payer types. Another member agreed that this is a logical point, but stated that executing it would be extremely difficult since the entire system separates Medicaid from non-Medicaid, and this is outside of the scope of this committee's work. Another member asked if it would be possible for the board association to determine steps that could be taken to move toward a more unified system.

The group continued to discuss this issue at length and seemed to agree that more work is needed; the current separation of Medicaid and non-Medicaid is not the most efficient and cost-effective system. A question was raised regarding the target starting date for the quality council. It was reported that this has not yet been determined. A Compliance & UR Team member stated that the team planned to wait until their work was formally closed out; at this point, they will make a frequency recommendation.

Revised ODADAS and ODMH interagency agreements with ODJFS were distributed to the group. It was reported that the ODADAS agreement is further into the internal ODJFS contracting process, and contains a signature page and boiler plate language that does not appear on the current ODMH agreement. As it moves further along in the process, the ODMH agreement will have the same language attached. An ODMH representative explained that page four of the ODMH agreement contains a section which describes the utilization review process in greater detail than the previous agreement, stating that utilization review will be conducted under the authority of JFS, who will consult with ODMH throughout the process. It was further stated that the ODJFS section in paragraph D explains that when a complaint is referred directly to ODJFS, it will be looped back to ODMH. It was also reported that more detail around the ability for boards to make a referral about a provider directly to SURS is also given on page eight in the ODMH section.

Some members felt that the ability for boards to refer directly to SURS was not sufficiently codified in the revised agreements. They expressed concern that what was discussed and agreed upon in the Steering Committee and Compliance and UR Team meetings was not accurately represented in the agreements. Other members stated that the documents do not prohibit this, and that the language contained in them is sufficient. It was stated that it would not make sense to specifically mention the boards in these agreements since they are not a party in the contract.

A member asked why clarifying that boards can go directly to ODJFS is such a big issue. It was stated that this was discussed as an option that they should have. The member stated that it is the options that have gotten us into the position we are in now, that the variance has been the concern all along. It was stated that the referral process document

is being updated and will be brought back to this committee, and that this document should help to handle the committee's concerns.

A member asked when the drafts would become final. It was stated that the agreements are still in the process, and that ODADAS and ODMH are working together to get both of them finalized at the same time. It was added that the ODMH agreement is approximately one or two days behind the ODADAS agreement in the finalization process. A question was raised regarding when this agreement expires. It was stated that it is valid through the remainder of this state fiscal year.

A member asked why the language requiring Medicaid contracts still remains in the agreements, since this is not a federal requirement. It was stated that part of the problem is that without the contract, some county auditors will not pay the bill, because there is no formal agreement between the board and provider. It was also stated that this is related to the Medicaid match issue, and will be re-visited at a later time.

Update on the Mediation Team

It was reported that the Mediation Team has met three times so far and that they are working to create ODADAS and ODMH rules under the existing 340 mediation requirements. Legal staff members who are participating on the team are finishing the final draft and expect to complete it in the next two weeks. It was reported that the team feels that its task, lining up statutory and regulatory requirements around mediation, is complete. They do not feel that they need to address the procurement issue at this time.

Another member stated that he feels that the group still needs to finish some work related to adding details to the rule. He stated that he took procurement "off the table" in the beginning. He reminded the committee of the three conditions for taking procurement off the table which were discussed previously: 1) develop a meaningful process for mediation, 2) assure that auditing process is truly independent and 3) resolve the sub-recipient v. vendor status issue. He also emphasized the importance of ODADAS developing a mediation rule and ODMH updating their current rule.

It was stated that the team will discuss whether statutory changes are necessary to enforce the mediation rule, and that one of the team's goals is for ODADAS to create a rule that brings the department into compliance, while changing the ODMH rule to mirror that of ODADAS. A member asked if there were any additional issues that need to be addressed. Another member stated that the process appears to give the state complete control, and that the team must act in a definitive manner around this issue.

Update on the MACSIS Team/Behavioral Health Operations Committee

It was reported that the team had its second meeting and is beginning to look at existing guidelines. A draft of the guidelines that was started two years ago was distributed and it was suggested that this be used to frame the current work. One item under review is the Usual and Customary Charge for providers. It was also stated that the Behavioral Health Operations Committee has not been utilized in a long time but could present an opportunity to answer questions and solve problems relating to MACSIS.

A packet of information about the Behavioral Health Operations Committee was distributed to the group. A member stated that this committee was originally part of the MOU but dropped out of subsequent MOUs because it is operational and not policy-related. It was stated that this committee was created to address operational MACSIS issues. Another member stated that the committee did not only address MACSIS issues, but other operational issues, including Medicaid/Medicare.

It was reported that information about the committee is still available on the ODMH website. It was originally decided that there would be a standing meeting for the group every 4th Thursday of the month, but this meeting has been consistently canceled since. It was stated that the group met a number of times, and substantive operational issues were resolved. A question was raised about what caused the committee to become inactive. It was stated that after issues were resolved and no more new issues were submitted, there was no need to meet. Committee members decided that the need for this committee will definitely increase in the future as re-engineering, quality improvement and standardization takes place. It was suggested and agreed that a reminder should go out that lets people know that the committee still exists to address operational problems, and that ODADAS should look into adding information about this committee to their website.

The committee then discussed the plan for transitioning from a MACSIS to a MITS system over the next four years. It was reported that the State is considering maintaining MACSIS, but using it as a payer of the Medicaid claim, directly from the state to the provider. In this scenario, MACSIS would be the adjudicator of the claim and an electronic interface with OAKS would allow for payment of the claim to be made directly to the provider. It was further stated that 835s would still go back to the boards, and non-Medicaid claims would be paid by them. A question was raised regarding whether this plan would have the potential to facilitate the transition to MITS later. A member answered that this would help with the transition; additionally, it would help pull Medicaid to the state, as a state obligation and risk.

A member added that an issue exists from the provider point of view; since the provider cannot always access the 835, it does not seem to be HIPAA compliant. Another member reported that the goal is for both the boards and the providers to be notified when a payment is made. A question was raised regarding whether this would also help to move to a weekly payment cycle. It was stated that this is a possibility, but it is unclear at this point whether it will happen.

Another concern was raised regarding cash flow and what would be expected of the boards. A member stated that boards often provide advances for non-Medicaid providers. Another member asked if boards are doing this for Medicaid only providers as well. It was stated that this is not being done; federal funds cannot be advanced. It was stated that there should be no issue with this since the non-Medicaid process will stay the same. Another member added that potential problems may exist, but should be addressed as they arise and should not stop this from moving forward.

A member expressed frustration with the fact that the guidelines exist but are not enforceable. He stated that the group is going through the guidelines when they should be

making this clear in regulation instead. Another member added that the group needs to reach an agreement about whether the work should now be focused on the short term or long term.

Update on Certified Public Expenditure Process

A member reported that ODMH IT staff has checked the volume of claims since July and compared it to what has been entered into the system. It was reported that only 45% of the claims and expenditures have been entered and are certified. Another member stated that all boards have registered as users and have staff working in the production site. It was reported that four or five boards are completely entered and certified, but the rest are not finished. It was stated that since the claims are not completely entered and certified, the state departments have decided to delay implementation for approximately one month. They will provide feedback to the boards to let them know what has and has not gone through to give them an understanding of where they are in the process. The committee decided that they will include a definite date of implementation in the communication sent to the boards, but will also ask each board that is not current to give a target completion date.

A question was raised about whether the EDI is complete and it was reported that it is moving forward but has not yet been completed.

Update on Audit Team

It was reported that at the last audit team meeting, the group was provided with a brief history of the audit guidelines. It was stated that the original guidelines were written at a time when Medicaid was smaller and as it grew, it was decided to consider providers sub recipients.

A member reported that ODMH and ODADAS are the last systems to consider providers as sub-recipients.

It was reported that the audit team members discussed the audit guidelines at length and seemed to agree that a simpler approach is needed. It was suggested that a policy framework, based on the agency's individual line of business, should be established. A member stated that in this framework, providers would rely upon their auditors to perform the appropriate audits, in compliance with the federal guidelines. This framework would also outline what is required under Medicaid, and would have an overarching guideline around audits which is based on the individual provider's prospective.

Another member added that he feels the guidelines are meaningless now, because a rule that requires providers to have an independent financial audit already exists. He stated that this rule separates financial audits from compliance and other issues. It is meant to ensure that the audits are transparent and truly independent from the payer.

The group decided that a communication should be sent to the boards that states that providers are now being considered vendors; the Auditor of State will be copied on this communication and will be directed to edit necessary documents, including the FACCR and the guideline handbook, to reflect this change.

Future Meetings

The group agreed to the following dates for future meetings. The meetings will take place in Rhodes, Room 806A, 1:30 – 4:30 p.m.:

November 19, 2008

December 18, 2008

January 15, 2009

**MOU Steering Committee Meeting
November 19, 2008
1:30 – 4:30**

Agenda

- Review and Approval of October 15, 2008 Minutes
- Update on the Compliance & Utilization Review Team
- Update on the Mediation Team
- Update on the MACSIS Team
- Update on the Audit Team
- Next Steps
- Future Meeting Dates

MOU Steering Committee Meeting Minutes
November 19, 2008
1:30 – 4:30 p.m.

Attendees: Don Anderson, Dan Arnold, Angie Bergefurd, Bill Bierie, Angela Cornelius Dawson, Fonda Dawkins, Doug Day, Jody Demo-Hodgins, Jodi Elsass-Locker, Carrol Hernandez, Rudy Rodriguez, Sandy Stephenson, Rick Tully, Cheri Walter, Hugh Wirtz

Review and Approval of October 15, 2008 Minutes

Minutes were approved with the following changes:

- Remove sentence at the top of page 4 which reads: “Board association representatives agreed that they could look at this, but would not be able to get around CARF issues, and could not promise that their system would look exactly like SUR.”
- Correct the misspelling of “HIPAA” on page 6 (remove extra “P”)

A reminder was distributed to the group regarding the Behavioral Health Operations Committee. It was stated that both OACBHA and the Ohio Council have already distributed a reminder. Heather King will send the ODMH reminder as well.

Update on Compliance and UR Team

It was reported that the public hearing for rescinding the 06 rule will take place on December 11 at 10 a.m. in the Rhodes Tower. It was also stated that the JCARR hearing is on December 29, and the only clearance comment received was in support of the rescission.

A member reported that during the Compliance and UR Team meeting on 11/3, the following occurred:

- The language from the interagency agreement was shared again
- The board referral process was finalized
- The team discussed standardizing the intake forms for referrals and decided that the ODADAS and ODMH forms will be combined
- It was reported to the team that the risk analysis exercise has been completed
- The team discussed scheduling of the Quality Council and decided that the first meeting will be scheduled in March or April, after the following three stipulations are met: 1)the interagency agreement is finalized, 2)the data exchange is taking place between ODJFS, ODMH and ODADAS, and 3)the 06 rule is rescinded.

The member stated that the next task of the team is to complete the final report to the Steering Committee. She added that the team will be working electronically to accomplish this task and will bring the report to the December 18th Steering Committee meeting. An OACBHA representative agreed that this report correctly reflects what happened at the team meeting.

The member also provided an update on the overview of the ODJFS Auditrac system on November 18th. She stated that ODJFS uses this system to track all audits. They have modified the system to include processes, reporting functions and tracking to be specific to ODMH and ODADAS reviews. Reports to the boards for sister agencies have also been drafted which provide details about the status of audits.

Concern was raised over whether trending back to the 2004 data would pose risks due to programmatic changes that have occurred since this time. It was reported that these changes were part of the risk analysis, and it was determined that nothing has changed significantly enough to prevent using this data as a baseline. It was further stated that the team decided upon going back to 2004 because HIPAA implementation took place prior to that year.

A question was also raised regarding whether a communication regarding changes in requirements resulting from the rescission of the 06 rule would be distributed to the field. A member expressed that he felt clarification should come from the State. A Compliance and UR Team member stated that this was discussed during the last meeting and the team decided that the final report would include this as a recommendation and may also suggest that some kind of training for boards and providers take place. It was suggested that this communication come from all three state departments.

Another member stated that she felt that more than one communication should be sent; she stated that sending a communication now will help work through the “unknowns” that will result from this change. She added that this could also help people to begin to think differently about how they view auditing compliance. Members agreed that sending out an initial general communication in preparation for the change, followed by more detailed instructions later would be beneficial. It was decided that the state departments would work on drafting this initial communication.

A member talked about the ODJFS date of death project and stated that they have been incorporating the mental health provider claims data in their ongoing reviews. The committee briefly discussed the concept of “cradle to grave” services, and it was stated that it appears that the system is not always updated when a client dies and this is resulting in claims which are incorrectly coded. It was suggested that the death data from ODH should go directly into the Medicaid system so that billing stops automatically, instead of re-writing the way CPST is coded after a client dies. It was stated that this was once an objective of ODJFS. Another member stated that the system may not be updated because ODH is often 2-4 years behind in statewide data. Members discussed the need for state agencies to address this issue and decided that it would be a suggested project for EMMA CET to consider.

Update on Mediation Team

It was reported that a mediation rule, written under the existing language, has been put out as a final draft. A member stated that a few comments have been received, and the rule will need to be edited before it is finalized. A draft final report is also circulating, and the team hopes to have both of these finalized before the next Steering Committee meeting on December 18th.

A committee member expressed disagreement with the opinion of some of the Mediation Team members that their work is complete. He stated that he felt that lining up current statute with a rule process is just the first step; broader components, in terms of the settlement, need to be addressed. The member suggested that the team discuss this at their next meeting and then decide how the rest of the work will be done. He added that the mediation process is still not meaningful, in that it is permissive and potentially avoids moving to a decision. He stated that the new mediation rule will tighten and frame the process, but does not provide anything that compels people to move through it.

The member also reminded the committee that it was agreed that procurement would be taken off the table under three conditions: 1) a meaningful mediation process is created, 2) the sub-recipient v. vendor issue is resolved and 3) a truly independent audit process is framed. He stated that the team needs to discuss statutory changes to ensure these things, and the Steering Committee needs to decide whether the Mediation Team will be responsible for the future work, or if another group should be charged with it.

A question was raised about whether the committee had ever discussed changing to a multi-year contract. It was stated that they did talk about the possibility of a two year contract and tying it to a biennial process. It was added that this would help ease administrative burden. Members decided that this would be discussed at the next Mediation Team meeting.

Update on MACSIS Team

It was reported that the team has set aside two all-day meeting dates, December 2 and 22, to focus on MACSIS guidelines and claims processing regulations. The team has drafted a document that contains updated MACSIS guidelines which provide clarification around items such as usual and customary charges. A member stated that the team needs to determine whether they are looking at short term or long term goals. He stated that in the short term, the system needs to be held accountable for the 30 day time frame for paying claims and the flow of information through accounts receivable needs improvement.

A member asked whether the 30 day requirement for paying claims is often not met. It was stated that this does occur frequently. The committee discussed when the 30 days actually begins, and it was agreed that this varies. It was stated that the CMIA requirement and the Medicaid requirement are different, and that the MACSIS team has tried to focus on the reimbursement component only. Another member stated that the beginning date of this 30 day requirement also varies from county to county and that accounts receivable often go out as late as 90 days.

Committee members agreed that enforcing the 30 day requirement will be difficult. It was suggested that instead of trying to fix what has happened in the past, the group could focus on moving forward with changes that will correct it in the future. A member expressed agreement with this but stated that enforcement will continue to be an issue.

It was suggested that this issue could be taken to the Behavioral Health Operations Committee. The group agreed that this is a good place for the discussion. Concern was raised that this issue would end up in discussion only and a solution would not be found. It was stated that this committee is fairly rigorous in trying to identify problems in real terms; they try to make recommendations quickly to solve problems. A member asked

whether this committee would be willing to look at issues out of this county and it was stated that they would.

A member stated that the 30 day requirement is a longstanding issue with MACSIS that has become more critical due to the economy. He further stated that anything that reduces or eliminates the current inefficiencies would be beneficial, and that moving to MITS will be helpful but may not happen quickly enough. Another member stated that if any quick fixes exist, they should be used. Concern was raised that waiting too long will result in loss of providers and services.

A member asked if the board association could do a survey of accounts receivable to see how often claims are paid past the 30 day requirement. It was stated that this was done two years ago and the survey indicated that one provider was paid in 38 days and the rest were paid within 30 days. It was added that the payment that was paid in 38 days took place in December, which is typically a problematic time. An OACBHA representative agreed that a study could be done to show the average time frame for claims payments, which claims are paid the latest and which are paid the soonest.

It was stated again that it is unclear whether the clock starts when the claim is submitted to the board or when it is adjudicated. A member added that these two dates are very different, and that the timing is impacted by whether a hub exists and how the submission of the claims is tiered. It was further stated that depending on the rules established by the entities, it may not be possible to get information regarding the status of the claim.

Update on the Audit Team

An Audit Team member reported that the team will be issuing a memo to state that providers will be considered vendors, for Medicaid purposes only, effective state fiscal year 2009. The member added that this memo will include instructions to providers and boards, which may be in various stages of the audit process, to ensure that they are not holding to standards which are no longer required. During their most recent meeting, the Audit team discussed timing of this memo, as well as necessary edits to interagency agreement language to reflect this change. It was suggested that the memo be distributed sooner rather than later, as it would be beneficial to send it as close to the end of the audit process as possible. A member also stated that the communication needs to be looked at from both a policy and a legal perspective.

The reporting Audit Team member stated that work related to the interagency agreement is not yet complete, but that it is clear that the FACCR and some of the audit guidelines need to be updated to reflect the change. The member also reported that after the team discussed looking at the guidelines at length it was agreed that they should look over the guidelines and determine if any additional rules will be needed. It was stated that the Auditor of State needs to provide a statement about whether they intend to write rules around the 340 requirements.

A member asked when the communication regarding vendor v. sub-recipient status would be distributed. It was stated that the draft will be ready soon, but it will not go out until the interagency agreement is finalized. The language which clarifies that the new vendor status is for Medicaid purposes only was just finalized and the agreement is now ready to

move forward. A member asked whether the agreement clarifies who secures the audit; it was stated that the memo will indicate that it is the responsibility of the provider to do so. Members raised concern that ambiguity will result from the differences between this communication and the 340 rule. It was stated that before a standardized approach is agreed upon, a response from the Auditor of State will be needed. The Audit Team is trying to determine the right person to contact at the Auditor of State's office regarding this issue.

Other Items/Next Steps

It was reported that most of the Ohio Health Plans Provider Enrollment Applications have been sent to ODJFS. There are a few outstanding, and numbers are still being assigned. ODJFS will notify providers when their numbers are assigned and give them instructions about using the IVR. A member stated that providers should be instructed to visit the web portal as soon as they receive this notice from ODJFS and change their password.

A question was raised regarding whether the state has started to talk about scenarios in which rate ceilings could be raised. The need for this was emphasized. It was stated that this has not been discussed yet. A member stated that after reconciliation is taken out of the process and fee schedule is in place, ceiling adjustments can be looked at service by service in both departments. A member added that the legislature also needs to look at service expansion.

A member indicated that the November 14 letter summarizing the system finance changes was very helpful and framed activities nicely.

MOU Steering Committee
January 15, 2009
3:30 p.m. – 5 p.m.

Attendees: Don Anderson, Dan Arnold, Angie Bergefurd, Bill Bierie, Angela Cornelius Dawson, Maureen Corcoran, Fonda Dawkins, Angela Cornelius Dawson, Doug Day, Jodi Demo-Hodgins, Bill Harper, Debbie Moscardino, Dalon Myricks, Rudy Rodriguez, Sandy Stephenson, Rick Tully, Cheri Walter, Hugh Wirtz

Review and Approval of November 19, 2008 Minutes

It was clarified that the “date of death project” is the correct term for the project in which ODJFS focused on provider claims that had been submitted for clients after they died. Minutes were approved with no changes.

Update on Compliance & Utilization Review Team

A member reported that the interagency agreement between ODMH and ODJFS is complete and signed. The interagency between ODADAS and ODJFS is not signed yet. ODMH will send an electronic copy of their interagency agreement to OACBHA and the Ohio Council. The public hearing and JCARR hearing have both taken place, and the effective date for rescission of the 06 rule is 1/19/09.

It was reported that ODMH, ODADAS and OACBHA members met to define the scope of what can be referred to agency certification offices. References to revised codes were added to the Board Referral Process Document; it was then finalized and distributed. It was noted that Fonda Dawkins did not receive this document, and Angie Bergefurd agreed to follow up with Lynne Lyon to ensure that Fonda receives it.

It was suggested that the group re-name the Quality Council, as it may be confused with the Clinical Quality Council. It was reported that a memo explaining the 06 rescission and the UR process will be distributed soon. The intention of this memo is to loosely frame the responsibilities of ODJFS to perform UR functions. The memo was drafted by ODJFS, and it will be sent not only by ODMH and ODADAS, but also the Departments of MRDD and Aging. In the ODMH and ODADAS version, information regarding the rescission of the 06 rule will be included. It was stated that this memo is much-needed and agreed that it would go out as soon as possible. Members agreed that the letter could be distributed in the next few weeks.

Update on Mediation Team

It was reported that the Mediation Team will be meeting tomorrow, and plans to complete the final draft of the rule language. They will incorporate this into their final report, which will be submitted to the Steering Committee for further instructions. It was stated that this should complete the work that the group was chartered to do. A member expressed that he felt that the work is only partially complete, that only a piece of the work is done. Another member stated that the team was charged with developing rules related to mediation and the roles of the departments. It was added that current charter work and project mission are complete, but this or another team may be charged with additional work after this final report is submitted.

Update on MACSIS Team

It was reported that the team is continuing to meet and going through the current MACSIS guidelines. They have discovered several issues which they plan to document soon. Some of these issues include problems with electronic interactions under HIPAA rules, as well as questions around the regulatory component and connections to the OAC. The team has also talked about whether the guidelines have real authority or if a broader opportunity to make regulatory changes exists. Another member reported that during the last meeting the group decided that language around hold and review protocol should also be included in the guidelines. The next meeting is scheduled for 2/4/09.

A question was raised regarding the payment of current Medicaid claims under the 30 day requirement. It was reported that OACBHA intends to study this. It was added that clarification around when the 30 day clock starts is needed. Issues regarding the transition to MITS were also discussed, including maintaining the capacity for retroactive eligibility. The committee also talked about Atlantes, which can be added to the MITS platform as a care or case management module.

It was agreed that the committee would like to have a copy of the all of the board business rules in order to better understand how they relate to MITS. Bill Harper agreed to send these rules to Angie Bergefurd so she can distribute them to the committee. It was clarified that since the business rules around Medicaid are consistent, but the non-Medicaid are not, only the non-Medicaid rules will be included in this distribution. The group continued to discuss variances in these rules across the boards. It was stated that they can range from no constraints to limiting CPST. Many of the rules are set up so that services are limited by the client's diagnosis.

A member stated that quite a bit of the current work will help with the retroactive claim problem. It was stated that severely disabled consumers who do not have Medicaid eligibility will suffer. Another member added that the focus should be on defining SMD, as right now the only way it is defined is by diagnosis and length of service. Several members agreed that better benefit service packages could cause needs to become visible and palpable enough to make funding easier to obtain.

Update on Audit Team

It was reported that Doug Day and Angie Bergefurd met with Tim Keen and other Auditor of State staff; they provided their staff with a packet of information including the Audit Team charter and ODADAS and ODMH financial and audit requirements, which differ between the two agencies. The Auditor of State requirements from a few years ago were also provided. They talked quite a bit about sub-recipient v. vendor status. The Auditor of State staff seemed to be interested in assisting and it was made clear that this is something that the team hopes to address before July 2009. Angie has left a message with Tim Keen regarding setting up a second meeting.

It was clarified that the team will not necessarily need approval from the Auditor of State's office to consider providers as vendors. A member emphasized that making a change to the ORC Chapter 340. This would address issues without involving the Auditor of State. The committee discussed possibly contacting the Auditor of State's

office to let them know that the team needs to work more quickly with them, or if this is not possible, proceed to make changes to the ORC Chapter 340.

A member stated that adding to the issue is the fact that the Auditor of State website states that they are required federally to monitor sub-recipients. It was agreed that the next steps will be to contact the Auditor of State's office, letting them know that boards are in agreement with the vendor status and to also draft changes to the ORC Chapter 340.

Miscellaneous Items

It was reported that ODMH has followed up with ODJFS to see if they have assigned Medicaid provider numbers, as ODMH has received no notifications. ODJFS reported that they should be going out now. A memo stressing that providers should set up passwords upon receiving their new numbers is ready and will be distributed when providers receive their numbers. It was stated that this will enable providers to do their own verifications without going through another company and will therefore be great for cost savings. It was clarified that this number is for behavioral health care agencies that do not have other lines of business. A member reported that Ed Zachrich stated today that he will be sending the notifications of provider number assignments in approximately 1-2 weeks. Dan Arnold will check with Ed tomorrow to confirm that these letters are being sent and will follow up with the committee.

It was also reported that ODADAS, ODMH and ODJFS are in the process of scheduling a conference call with CMS to discuss the response to the RAI; the first week of February is the targeted timeframe for this call. The state agencies hope to have a draft response ready by the middle of the week next week.

A question was raised about the outcome of last week's budget cut meeting and the movement of Medicaid match responsibility. It was stated that the state has a clearer agreement of what variables will be used in the budget cuts. They are still running scenarios but should know by tomorrow what the recommendations will be. It was added that the impact is going to be significant for many boards. The formula applied 80% per capita, 20% Medicaid; the range of cuts to the 505 base from 21% to over 50%. In the end, this variance was narrowed by approximately 8 percentage points, bringing it to 35% to 43%. It was stated that a number of areas will be held harmless, as paying what they owe would most likely force them to close. These include approximately 6 counties, all of which are Appalachian, with the exception of Ashtabula.

A member reported that the discussion around the movement of Medicaid match responsibility (Medicaid elevation) went well. It was stated that the boards are not opposed to it, but do not want it to happen in the next biennium. A member disagreed with this statement, saying that not all boards agree with Medicaid elevation. She further stated that her impression was that this topic was still being debated. Another member stated that the Governor's Office and OBM also believed that the boards were clear that they did not oppose it, but wanted to wait until after the next biennium to make the change.

Board concerns regarding Medicaid administrative claiming were discussed among committee members briefly. It was stated that the boards will be involved in Medicaid claiming without compensation until the entire process moves to the MITS system, approximately 5 years from now. Medicaid claiming will stop at that point, but it is unclear what will happen to non-Medicaid claiming. There was also some discussion about whether it was actually agreed that Medicaid elevation would take place. Most members seemed to believe that it was agreed that this policy change should take place, but the timeframe and other issues are still being ironed out. A member added that the state would support the submission of a fee schedule to CMS and that this would be moved along as quickly as possible. The boards will move forward with MAC as well.

It was suggested that these and other issues could be addressed in a “common concerns” group similar to the one that convened prior to the Mental Health Act of 1988. A member suggested that this group could be structured into the budget language in order to give it priority and focus. It was also stated and agreed that this group could include legislators as well, to emphasize its importance. Another member stated that clear parameters and rapid decision making will be important for the group if they are to succeed.

It was stated that the “common concerns” group could be used to build upon the work that the MOU Steering Committee has already done. A member added that the group could consist of providers, boards, consumers and family members. The committee agreed that this group should consist of approximately 15 members, which could possibly branch out into different subgroups.

The committee also discussed current work that is being done with benefits packages. It was stated that the committee should try to come to an agreement about the utilization management packages at the next meeting. A member stated that the work underway using synthesis and clustering is excellent, but there is concern that it will take too long because the process is very precision oriented. It was further stated that this work should continue, but basic packages, based on the work that is already done, could be used in Medicaid and non-Medicaid. As the work continues, the packages could then be refined.

Members agreed that today’s system is not based on client need. It was stated that the current work around benefit packages is being done with a goal to agree upon a uniform approach to utilization management, not to turn anyone into a managed care entity. A member expressed that she believes the synthesis and cluster work will help to better understand real need and real cost in our system. Concern was raised about moving to benefits packages without addressing the issue of problems in the current system. It was stated that building upon a broken system could be detrimental to providers. The committee agreed that they should draft a document containing bullets of what is agreed upon as well as where disagreements lie for the next meeting.

Next Steps

A proposal will be drafted, outlining the following items that the group has agreed to move toward:

Discuss Medicaid elevation by 7/1/11

Moving forward on fee schedule

Moving forward with MAC

Bring together a “common concerns” group

Bring together a group to develop simpler, more basic benefits/service packages based on the work around synthesis and clustering.

Address Reimbursement Methodology Issues

Future Meeting Dates

2/11: 1-3 p.m.

3/11: 1-3 p.m.

4/15: 1-3 p.m.

MOU Steering Committee Meeting

2/11/09

Agenda

- Review and Approval of January 15, 2009 Minutes
- Update on Compliance & Utilization Review Team/Review and Approval of Final Report
- Determine Behavioral Health Utilization Review Council Membership
- Update on Mediation Team/Review and Approval of Final Report
- Update on MACSIS Team
- Update on Audit Team
- Budget Updates
- Behavioral Health Systems Transition Work Group
- Next Steps

MOU Steering Committee Meeting Minutes
February 11, 2009

Review and Approval of January 15, 2009 Minutes

Minutes were approved with the following edits:

- Change “Medicaid Elevation by 7/1/11” to “Discuss Moving to Medicaid Elevation by 7/1/11” on the list under “Next Steps.”
- Add “Address Reimbursement Methodology Issues” to same list.

Miscellaneous Items

- A question was raised regarding whether ODADAS plans to continue the Synthesis Cluster work since it seems to be geared more toward mental health and ODMH is much further along in the process. It was stated that ODADAS is not able to move forward any further with this work as it relates to benefit packages and plans to look at what other states are doing in this area.
- It was reported that the ODMH/ODJFS Interagency Agreement is now posted on the ODMH website.
- An ODJFS representative stated that 123 letters assigning Medicaid provider numbers will be sent today. Approximately 20 or 30 applications received were incomplete and the remaining agencies have not submitted applications. Members noted that this seems to indicate that a large number of agencies still have not submitted applications.
- An ODMH representative added that a follow up letter is prepped and ready to be sent to each agency that is assigned a Medicaid provider number. It was agreed that a copy of this letter would be sent to Hugh Wirtz.
- A member asked whether eligibility could be checked by batching client names. It was stated that ODJFS has discussed the need for this ability, but it is unknown whether it is possible at this time. Another member asked whether it would also be possible to determine the date that the client became eligible for Medicaid. Debbie Moscardino agreed to follow up on this; she believes it is possible.

Update on Compliance & Utilization Review Team/Review & Approval of Final Report

The final report was distributed and discussed. It was stated that the team would like to get final approval from the committee today. A member added that the team needs to know whether the UR update letter included in the packet will be sufficient, or if the committee would like another letter from the three directors to be distributed.

The group agreed that a more detailed letter from the directors would be sent. This letter will include information contained in the final report upon its approval.

A question was raised regarding whether membership of the Behavioral Health Utilization Review Council had been determined yet. It was stated that this has not been

determined because the team is waiting for approval of the final report. A motion to approve the final report was made and seconded; there were no objections.

Determine Behavioral Health Utilization Review Council Membership

A member asked the committee to submit recommended names for membership on the council. The committee discussed how consumer representatives will be chosen. It was suggested that the committee contact the group who has been working to reorganize consumer advocacy to make recommendations. A member reported that this was discussed during a meeting today. It was stated that the group talked about including the same people in different councils, since their work often overlaps. A member also emphasized the need for AoD and MH providers for both kids and adults to be represented in the membership.

Another member suggested that the names be submitted by February 20, 2009. It was also recommended that consumer operated services be represented. The committee discussed how often the group would meet and how large it would be. It was stated that there are currently eighteen slots for membership. An ODJFS representative stated that the department will not need 3 representatives on the council. Some members felt that consumers should have more than one representative.

It was agreed that Angie would send an e-mail requesting names for the council which will provide more detail around often it will meet and when it will begin. The group agreed that initially the council would probably meet every 4-6 weeks and then meet quarterly later. A member stated that creating more targeted agendas and meeting less often will make it easier for members to attend.

The group also agreed to try to get the recommended names by February 20, 2009. The committee discussed time-limiting this group. One, two or three year terms were suggested. It was also suggested that different individuals could rotate serving on the council in the same position.

Update on Mediation Team/Review and Approval of Final Report

The Mediation Team Final Report was distributed and discussed. It was stated that the team would like to receive approval from the committee to finalize the report. A member stated that he felt the work on the rules was good and dealt well with ambiguities, but he also believes that in terms of the MOU agreement, the work around this is still not complete. It was agreed that another group should be charged with finishing this work. A motion to approve the final report was made and seconded; there were no objections.

Update on MACSIS Team

It was reported that the MACSIS Team has been working through the guidelines page by page. This has been time-consuming but helpful in understanding the MACSIS claims process. The group plans to schedule full day sessions for their work.

Update on Audit Team

It was suggested that the group focus on two items separately: provider sub-recipient vs. vendor status and provider financial audit guidelines. It was reported that the target date

for moving providers to vendor status is still July 1, 2009. Members expressed concern that the team is running out of time. Part of the issue is that the State Auditor's office is now involving legal staff, which is making the process more time consuming. Although this year is preferable, this work could definitely be completed by 2010. The committee agreed to focus on these two items separately as suggested. An e-mail will be sent to update the Audit Team and they will begin to meet again.

Budget Updates

It was reported that the state is currently in a "wait and see mode" regarding the federal stimulus package. ODMH plans to move forward with testimony according to the current budget. A member stated that the sister agencies need to be very concerned about how to move ahead without federal stimulus money. She added that they need to talk specifically about how to address the needs of the highest risk consumers. It was further stated that regardless of whether relief comes from the federal stimulus money, the agencies will need to do some tough planning and make difficult choices.

A member asked whether RSS cuts have been addressed. It was stated that it was not appropriately addressed in the ODMH budget testimony, but that ODMH recognizes the importance of this issue and raises it whenever possible. It was added that the only RSS that is in the budget is allocated for home repairs and upgrades. ODMH and ODADAS are slated to give testimony on February 25, 2009.

It was also reported that the recovery website is now running. Committee members agreed that this website will be very important, especially to boards and providers. It was stated that boards and providers should register on this website now and that a formal application process will follow. It was reported that approximately 22 different programs exist in which they might be interested. ODMH intends to send a memo outlining these programs and encouraging them to join the website. It was clarified that this website was initiated by the Governor's office, not the Ohio Department of Health (although it does use IT from ODH).

It was stated that the federal stimulus bill contains added BH language. In order for vendor products to qualify, they must be certified as a CCHC. Currently, only two of the national BH products meet this qualification. A member expressed a need for improving documentation requirements. It was stated that although many organizations cannot invest in web-based technology, it would be beneficial to do so. It was reported that ODMH has a meeting scheduled to discuss this in the near future.

A member added that the senate version of the federal stimulus bill did not contain language around extending Medicaid regulations, which could be a huge hit to reimbursement of Medicaid services. It was stated that negotiations are supposed to be over this week.

Behavioral Health System Transitions Work Group

A document outlining the scope of work for the new Behavioral Health Systems Transition Work Group was distributed and discussed. It was stated that this document was created based on the list of projects outlined in the next steps at the last committee meeting. The purpose of this group is to pull forward the incomplete MOU subcommittee

projects, such as the work of the quality council, sub-recipient vs. vendor status and provider financial reporting responsibilities.

It was stated that some of the same subcommittee members may need to be involved in the BH System Transitions groups. A member stated both Medicaid and non-Medicaid needs to be considered when defining amount, scope and duration of services. It was agreed that three joint committees, involving both ODMH and ODADAS, will be formed around definition of priority populations, defining amount, scope and duration of services and benefit package development.

The committee agreed that defining priority populations should come first. It was stated that the first short term work, which is already underway, is around the ODJFS transition and interface between MITS and MACSIS. The long term work involves the migration to MITS. It was added that the ICD10 work will be cost prohibitive. A member expressed the need to devise a strategy for this work. It was stated that there are two separate deadlines for new requirements around ICD10 and Version 5010, which are in the years 2012 and 2013. A member reported that Diamond is going to use the same amount of characters, which eliminates issues with these requirements.

Additional Items

It was stated that the boards were under the impression that a common concerns group was to be formed before Medicaid elevation was added to the budget language. A member stated that it has already been submitted in the language. A question was raised regarding whether language around involving legislators was included. It was stated that this is not clear, as no one has seen the language in its final form. A member stated that the common concerns group will include providers, boards, consumers and families, as well as the state.

Concern was raised that the group will need to address Medicare as well. It was stated that financial burden on providers will be worse if it is not addressed, as a large group of priority people are Medicare eligible only. It was suggested that this could be part of the conversation that will take place around defining priority populations. A member added that conversations have already taken place about shifting populations; it was evident that if people are defined as a priority population but cannot get in because of payment type, the definition will be meaningless.

The member asked whether Medicare payments have increased recently; it was reported that they have, but over a five year period. It was stated that core reimbursement is still a problem, and that in some communities with levy support, this becomes a political issue.

The committee also discussed housing issues. Concern was raised that this was going to become a larger problem with or without the federal stimulus money. Members also briefly discussed alternative ways of finding funds for housing, such as TSIG. It was agreed that this could be discussed in the oversight group (BH Transitions Work Group) or in a subcommittee to be formed later. They also agreed that work force could be addressed in this way.

A motion to approve Transitions Work Group document with the following changes was made and seconded; there were no objections:

- Add “as directed by the budget bill and/or the BH Transitions Work Group” to Medicaid Elevation Group bullet.
- Add an Emerging Health Care Policy and Information Technology Initiatives group as a subcommittee

The group also discussed membership of the BH Transitions Work Group. They did not reach an agreement regarding how many representatives each group would have. It was agreed that it would be smaller than the MOU Steering Committee and would involve different people.

It was stated that the MOU is “off the table” with the exception of the work to be completed by the BH Transitions Work Group. A member suggested that legal staff be contacted to confirm this.

Next Steps

This is the final meeting of the MOU Steering Committee. The meeting that was scheduled for March 11, 2009 will be the first meeting of the BH Transitions Work Group.