New DOO Review
(Detailed Oversight Observation)
February 9, 2018
Facilitators: Chief of Staff, PMO Lean Six Sigma Team
New DOO Review

» Team Members:

- Bibi Manev, Heather Hire, Tara Stokes, Wayne Morgan, Meghan Duvall, John Haller, Joe Pichert, Lynda Zamora, Brandi Potts, Vanita Curry, Brandi Nicholson, Jim Rosmarin, Karla Warren, Megan Powell, Joel Lodge, Laura Leach, Elbony McIntyre, Jessica Nienberg, Hope Roberts, Brock Robinson, Dan Kiser, Monica Peck, Carol McC Chesney, Mary Bartlett, PCG: Angelene Willetts-Carvi, Sally Ratermann, Brandy Dickman, Jennifer Wilkens, AAA/PAA reps Jenny Janda, Diane Phillips, ODA-Meredith Finley, Kristen Harkness, Matt Hobbs, Jennifer Stires, fresh perspective - Cheri Hatfield
How Did We Get Here?

• Structural reviews for waiver providers who work with ODM are contracted to PCG which uses the Carestar Information System (CSIS).

• Other agencies, like ODA, DODD and ODH, also conduct structural compliance reviews because they are governed by their own set of rules and use separate systems to collect information.

• Thus, structural reviews are not currently interchangeable so providers may be subjected to several structural reviews in one calendar year which causes hardships and provider retention problems.
Projected Benefits

• Improved provider and agency morale
• Potential cost savings by reducing the number of structural reviews
• Potential higher provider retention
• Increased training/technical assistance opportunities for providers
• More accurate claims submissions
• Greater consistency in review will result in greater consistency of service across the state
Level Setting
Process Improvement Goals

- Streamline structural reviews so that one review fits needs of both agencies
- Reduce the number of structural reviews for a provider to one per calendar year
- Benchmark other state agencies (i.e. DODD) and other states to determine best practices
- Determine ideal future system for structural review
Event Scope

• What is the first step in the process?
  » Our process begins with …

• What is the final step in the process?
  » Our process ends with …

Notification that a structural review is due

Plan of correction is accepted by the respective agency
### SIPOC

#### Suppliers
- Providers
- ODM
- ODA
- ODH
- DODD
- Accreditation Agencies
- PCG

#### Inputs
- OAC Rules
- SR forms
- CSIS - ODM
- PIMS - ODA
- DODD’s system?
- ODH’s system?
- MyCare plans
- Claims review in MITS
- Accreditation System

#### Process

<table>
<thead>
<tr>
<th>Step</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Notification that SR is Due</td>
</tr>
<tr>
<td>2</td>
<td>SR scheduled</td>
</tr>
<tr>
<td>3</td>
<td>Documentation Gathered</td>
</tr>
<tr>
<td>4</td>
<td>SR takes place</td>
</tr>
<tr>
<td>5</td>
<td>NOD issued</td>
</tr>
<tr>
<td>6</td>
<td>POC reviewed</td>
</tr>
<tr>
<td>7</td>
<td>Deficiency response accepted</td>
</tr>
</tbody>
</table>

#### Outputs
- SR
- NOD
- Sanctions

#### Customers
- Providers
- Managed Care Office
- Agencies
- Members
Level Setting

- We conducted 20+ interviews called Voice of the Customer to learn about the process:
  - ODA employees
  - ODM employees
  - Managed Care Plans
  - PCG
  - Waiver Providers

- Here’s some of the VOC we heard.
## Project CTQ

<table>
<thead>
<tr>
<th>Environment</th>
<th>Measure</th>
<th>Man</th>
<th>Method</th>
<th>Material</th>
<th>Machine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultimately want to see if provider provided and billed for services correctly</td>
<td>PCG does 300/month for the 7500 independent providers</td>
<td>Interagency “buy-in” complicated; this has been tried before</td>
<td>Provider must certify with each state agency they provide services for</td>
<td>One annual BCI should be enough</td>
<td>ODA has a portal BEFORE the info comes over to ODM</td>
</tr>
<tr>
<td>Had a provider leave OH for MI since they’re “easier to work with”</td>
<td>Assumption that there is a decrease in # of independent providers who accept managed care</td>
<td>Personal bias from reviewers?</td>
<td>Waiver requirements are different across the waivers</td>
<td>“A waiver is a waiver”</td>
<td>CareStar – old system, PCG uses it</td>
</tr>
<tr>
<td>Ancillary agencies have not had a review since PCG took over the contract....5 years ago!</td>
<td>Worry about decline with EVV</td>
<td>Review scheduling..</td>
<td>Don’t know the name of the beneficiary being cared form on provider claims</td>
<td>Tax affidavit; form should refer to the rules</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MCP’s do Unit of Service Verification AND review 10% of claims according to guidelines from ODA 2x year; plans are responsible for any recoupment in this instance</td>
<td>Pain point: providers who do not keep their records; can take 6 weeks or more to receive documentation (MCP claims review)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How can we all speak in one voice?
When providers do not show, PCG conducts a 12 month billing review.
- PCG also writes a NOD
- Average of 3,000 per year
- 25% in 2016 and 27% in 2017
ODM Agency Providers not reviewed

- Home Delivered Meals
- Supplemental Transportation
- Emergency Response Services
- Adult Day Center
- Home Modifications
- Out of Home Respite Services
- Supplemental Adaptive and Assistive Services
ODA On-Site Compliance Reviews

- 2016: 2146
- 2017: 2296
Summary

• Opportunity to align the Structural Reviews to get to one format
• Opportunity to try to get more providers to a Structural Review upon initial request
• Opportunity to review other systems
Current State
Current State Process

- 2 separate processes
- 211 Process Steps
- 38 Decision Points
- 41 Wastes
- Multiple Loopbacks
- 4 Value Added Process Steps
Examples of TIM U WOOD Waste

- Each of the 13 PAA’s have their own process
- 12 months of records required for review for all providers
- Provider documentation is not standardized
- Need to share areas of non compliance (e.g., timesheets and consumer record deficiencies)
- Need threshold for “compliance” – what is good enough
- Lack of centralized monitoring depository results in manual file transfers
- ODM looping back to PCG after NOD is issued for POC process
- Provider no shows waste valuable resources in cost and prep time
- Defect: risk of no or poor quality service to MyCare members
Value Added Steps

• Value Added Processes
  » Schedule the review or engaging the provider
  » Conduct exit conference including education with provider and providing technical assistance
  » Review Plan of Correction
  » Interaction with AG office on potential Medicaid fraud cases
Brainstorming
Brainstorming Ideas

• There were over 127 brainstorming ideas generated
  » Brainstorming ideas were lumped into the following 5 categories:
    – Systems Changes
    – Roles and Responsibilities
    – Training
    – Forms
    – Procedures/Policies/Rules
High Impact High Control Examples

• High Impact/High Control ideas to be considered for the Future State:
  » Change training messaging to focus on process improvement or technical assistance instead of punishing the provider
  » Provide a full protocol like DoDD on how a structural review is conducted
  » Provide handbook for providers on expectations so they can understand the process
  » More electronic forms, tools, processes to reduce paper clutter
  » Figure out a good way for ODA and ODM sanctions to be shared with managed care plans (e.g., file transfer) – already underway
  » Develop one system (not PIMS, not CSIS) for all structural reviews
High Impact Brainstorming Ideas continued

• Rule/Policy Change Requests:
  » Consistent OAC rules for compliance reviews and disciplinary actions (multi-level sanctions)
  » Give providers only one plan of correction (either from PCG or ODM)
  » Have one review for nurses (either ODM or ODA)
  » Shorten from 45 days for providers to respond to citations with their plan of correction (e.g., 30 days, 15 days)
  » Add score or grade or extra benefit to help provider to succeed
  » Change rules to have a claims/$ consequence for frequent non-compliance with a communication mechanism to the MCPs
Future State Process
Our New Future State

• Planning for an ideal future state started with two separate groups developing clean sheet redesigns of the current state process

• The best ideas/strategies from each clean sheet was incorporated into one ideal future state process map
Future State Summary

- One process for ODM and ODA provider reviews
- Streamlined POC and sanction process
- Emphasis on training, education and technical assistance
- One future universal provider review system
- Reduction of processing of no shows
- Increased number of structural provider reviews completed
- Eliminate multiple reviews
- Greater assurance of quality healthcare
Implementation
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>What Needs to Happen</th>
<th>Who Will Take Lead</th>
<th>When Will It Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems</td>
<td>ODM to determine how to pull data and track trends of non-compliance</td>
<td>Workgroup</td>
<td>Mary B., Brandi D, Kristen</td>
<td>60 Days</td>
</tr>
<tr>
<td>Systems</td>
<td>Data drop to share sanctions with Managed Care Plans. Hold on referrals and/or removal of cons.</td>
<td>Determine plan of action</td>
<td>Wayne, Meredith</td>
<td>30 Days</td>
</tr>
<tr>
<td>Form</td>
<td>Update form requesting higher level sanction</td>
<td>Update form</td>
<td>Meredith</td>
<td>90 Days</td>
</tr>
<tr>
<td>Form</td>
<td>Standardize Structural Review form criteria for alignment with MLTSS (post rule alignment)</td>
<td>Develop new form</td>
<td>Jim R., Matt H.</td>
<td>&gt; 90 Days</td>
</tr>
<tr>
<td>Form</td>
<td>One referral to ODM for NOD &amp; SUR referrals and POC</td>
<td>Determine plan, feasibility and value</td>
<td>Heather, Dan, Tara Angelene</td>
<td>60 Days</td>
</tr>
<tr>
<td>Form</td>
<td>Develop provider surveys after compliance review to get feedback</td>
<td>Develop survey</td>
<td>Mary G</td>
<td>90 Days</td>
</tr>
<tr>
<td>Roles &amp; Responsibilities</td>
<td>Case Management to check on consumer when the provider is non-responsive</td>
<td>Determine plan, feasibility and value</td>
<td>Wayne, Kristen, Mary</td>
<td>90 Days</td>
</tr>
<tr>
<td>Roles &amp; Responsibilities</td>
<td>ODM to resume agency compliance reviews</td>
<td>Just do it</td>
<td>Wayne, Tara, Bibi</td>
<td>90 Days</td>
</tr>
<tr>
<td>Training/Education</td>
<td>Require provider training prior to enrollment</td>
<td>Develop curriculum &amp; training</td>
<td>Jennifer, Meredith, Kristen (ODA), Wayne, Brock</td>
<td>&gt; 90 Days</td>
</tr>
<tr>
<td>Training/Education</td>
<td>PCG/ODA complete a 90 days review with providers within the first year of enrollment</td>
<td>Change PCG Contract, Develop review form, etc.</td>
<td>Bibi, Tara, Jennifer (ODA), Megan (ODM)</td>
<td>&gt; 90 Days</td>
</tr>
<tr>
<td>Training/Education</td>
<td>Once programs are aligned, develop universal training for all reviewers. For Aging, ensure one training for all regions</td>
<td>Develop universal training for all regions</td>
<td>Angelene, Tara, Kristen, Meredith</td>
<td>&gt; 90 Days</td>
</tr>
<tr>
<td>Training/Education</td>
<td>Develop a full protocol (like DoDD) on how a structural review is conducted</td>
<td>Transparent structural review protocol and tools accessible to providers</td>
<td>Jennifer, Kristen, Meredith (ODA), Heather, Tara (ODM)</td>
<td>&gt; 90 Days</td>
</tr>
<tr>
<td>Procedures/Policy/Rules</td>
<td>Develop single OAC rule for all NF based waivers</td>
<td>Align ODM and ODA OAC rules</td>
<td>Jim R., Matt H.</td>
<td>Goal effective date 1/1/19</td>
</tr>
<tr>
<td>Procedures/Policy/Rules</td>
<td>Standardize what happens when a provider does not comply</td>
<td>Develop new standard procedures for ODM &amp; ODA to follow</td>
<td>Jim R, Meghan, Matt H</td>
<td>Goal effective date 1/1/19</td>
</tr>
<tr>
<td>Procedures/Policy/Rules</td>
<td>Standardize review process protocols</td>
<td>Workgroup</td>
<td>Heather, Tara, Wayne, Matt H, Kristen</td>
<td>Kick-off by 3/2018; goal completion date 11/1/18</td>
</tr>
<tr>
<td>Procedures/Policy/Rules &amp; AG</td>
<td>Determine what data can be provided for MyCare &amp; AG</td>
<td>Research</td>
<td>Brandi N.</td>
<td>3/7/2018</td>
</tr>
</tbody>
</table>
Dashboard – What Gets Measured Gets Done

• Provider List – Who needs reviews, due dates
• Standard Compliance Grid (Review)
• Standard Sanction Grid (State)
• AG open case list
• Access to billing (if needed) or # of consumers being served by provider
• Database to upload provider documentation
• EVV data access
• Standardized review tools
• Data Analysis:
  » Citations/Sanctions Numbers and Types of Violations
  » Timeline Compliance
  » Timeline of provider review process
  » Trends ( terminations, deficiencies, sanction, etc)
  » Timeline of sanctions/POC
  » Data by Plans (# of providers, # of non-compliances)
  » Provider Regional certification by county and service
Decisions Needed from Senior Leadership

• Give PCG the ability to pull billing data directly for Medstat process (beginning of SR process)
  » Current hurdle but there is potential with the new OMES Provider module to overcome this barrier

• Recommend that we separate billing and overpayments from the Structural Review process and give to the appropriate team that understands this piece

• Establish a workgroup to prioritize and authorize rule changes

• Single rule (including frequency and type of review) authorizing structural reviews conducted across agencies – waiver provider SR Process Rule
Questions or Comments
Special Thanks to...

- **Senior Leadership:**
  - Director Sears, Jenelle Hoseus, Beverly Laubert, Matt Hobbs
- **PMO Director:**
  - John Pendergast
- **Sponsor:**
  - Patrick Stephan, Ebony McIntyre, Jessica Nienberg
- **Team Lead:**
  - ODA – Karen Boester
  - ODM -- TBD
- **PCG**
  - Sally Raterman, Angelene Willetts-Carvi, Brandy Dickman, Jennifer Wilkens
- **ODA/PAA:**
  - Kristen Harkness, Meredith Finley, Jenny Janda, Diane Phillips
- **Green Belt:**
  - Amanda Gillespie
- **Black Belts:**
  - Betty Birt, Debora Mayle, Felicia Sherman
- **Belt Assistants:**
  - John Haller, Vanita Curry, Joe Pichert, Brandi Potts, Irene Barnett, Cheri Hatfield, Lynda Zamora
Appendix A

Linkages to ODM Strategy Map
Increase Value for Taxpayer Dollars

• Process improvements help prevent provider overbilling
• Helps prevent Medicaid fraud by drawing attention to issues and concerns that lead to overbilling
• More efficient use of resources that lead to consistency
• Editing unneeded steps allows us to move forward with less needed man power and less expenditure of tax dollars (also means more money to pay for health care results in Superior Health Outcomes)
Consistent & Rewarding Business Partner

• More training for providers
  » Improve and develop better providers by tracking and addressing problem areas
• More timely interaction/follow-up/action taken with providers
• Increase collaboration with PCG
• Improve provider education to ensure they clearly understand ODM’s expectations
• Improve data collection to increase compliance with federal regulations
Easy to Work With

• Defined expectations help providers, recipients, business partners and tax payers understand next steps
• Process improvements lead to efficiency and better process results
• Providing education videos help providers to meet compliance guidelines and improve service delivery
Additional Perspectives

• Innovation and Continuous Improvement
  » Use of online training to address current NOD backlog and improve quality of services
  » Ability to track status of NODs
  » Decrease paperwork leading to more efficiency

• Performance Management
  » Timelines to keep workflow moving
  » Ongoing quality assurance by ODM
  » Improved transparency
MAKING OHIO BETTER