Ohio | Department of Medicaid

Building the Basics

Ohio Council of Behavioral Health & Family Service Providers

Ohio Department of Medicaid

October 21, 2023

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Next Generation Program Updates

Next Generation of Ohio Medicaid Implementation

Vision for Stages 2 & 3

1 July 1, 2022

OhioRISE

OhioRISE has begun providing specialized services, which will help children and youth with behavioral health needs and aid coordination of care for those who receive care across multiple systems.

2 October 1, 2022

Provider Network Management (PNM) / Centralized Credentialing and **Single Pharmacy Benefit Manager (SPBM)**

Centralized Provider Credentialing has begun reducing the administrative burden on providers. Also, the **Single Pharmacy Benefit Manager (SPBM)** has begun providing pharmacy services across all managed care plans and members.

3 December 1, 2022

Next Generation Managed Care Plans, Streamlining of Claims, Prior Authorization, and **other Administrative Submissions through OMES**

Next Generation managed care plans will be implemented during this stage. Members will experience benefits that help address their individual healthcare needs, such as increased access to care coordination and care management supports. ODM will implement the Fiscal Intermediary (FI) and EDI for additional improvements to **streamline claims processing, prior authorization requests, member eligibility requests, and claim status inquiries and attachments** for providers and trading partners.

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Next Generation of Ohio Medicaid Key Improvements

We listened to you – our members, over 1,000 healthcare and behavioral health professionals, and community leaders across the state. Your feedback led us to make exciting changes and improvements for Ohio Medicaid's managed care program so we can serve you better.

OhioRISE

Better Services for Pregnant Members and Newborns

Commitment to Each Individual's Health and Cultural Respect

After-Hours Behavioral Health Crisis Services

Enhanced Support for Member Transportation

24/7 Medical Advice Line

Telehealth Services

Community Investment

Increased Accessibility

Additional Support for Children

Focus on Preventive Care and Wellness

Individualized Coordination and Care Management

Single Pharmacy Benefit Manager (SPBM)

Freeing Up Providers to Better Serve You

Managed Care Provider Agreement Changes: Themes

Next Generation of Ohio Medicaid's Managed Care Provider Agreement

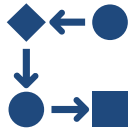
The next generation provider agreement includes a variety of changes to focus on the individual rather than the business of managed care

Improvement in Member Access to Services

Increasing timeliness and access to information and services (e.g., telehealth)

Care Management & Coordination

Strengthening requirements to emphasize disparity reduction and health efforts (e.g., implementation of high-performing care coordination program and health navigators)



Greater Consistency/ Processes for Providers

Revising processes to increase timely and accurate notifications and ease administrative burden (e.g., standardization of MCO notification for authorization submission)

Enhanced Support for Member Transportation

Providing enhanced transportation service coordination and a dedicated call center selection with trained staff to support members (e.g., member services call center and MCE provided transportation over 30 miles from member's home)

Increased Program Transparency & Enhanced Accountability

Increasing transparency and access to data along with accountability of quality improvement projects (e.g., ODM remote connectivity to all data relevant to care provided to members)

Operating Agreements for All MCEs

Establishing improved payment and communications timelines in all MCE operating agreements (e.g., coordination between MCEs, OhioRISE, and the SPBM to develop written agreements)

Population Health

Employing population health management principles to address health inequities and disparities to achieve optimal population outcomes (e.g., MCEs identify disparities, partner with community-based organizations, and follow-up on needs)

Community Based Engagement

Demonstrating a commitment to improving health outcomes in local communities through community reinvestment activities (e.g., MCE contribution of its annual after-tax profits to community reinvestment)

Support Providers in Better Patient Care

Support Providers in Better Patient Care

To reduce provider burden and promote consistency across the Ohio Medicaid managed care program, ODM has retained the administrative responsibilities for centralized claims submissions and for credentialing and re-credentialing.

Key Changes Included in the Future Managed Care Provider Agreement

Standardizing Service Authorization

- Standardizes and streamlines MCO service authorization processes for providers
- Ensures competencies of MCO reviewers and that peer-to-peer consultation is made available to providers

Fiscal Intermediary

- Reduces the administrative burden on providers by requiring MCOs to develop necessary electronic exchanges or EHRs, along with coordinating service authorization requests through ODM's fiscal intermediary
- Requires MCOs to give ODM real-time, read only access to MCOs' service authorization systems

Centralized Credentialing

- Streamlines administrative process and increases ODM's access to high quality, aggregated data by implementing a single credentialing process
- Bars MCOs from requiring any additional credentialing information from an ODM-enrolled provider

Standardizing Overpayment Recovery & Claims Timeframe

- Supports standardization of the recovery process of overpayments across MCOs and claims timeframes
- Requires MCOs to extend the timeframe for accepting claims, and reduces the time MCOs have to pay claims

Clear Provider Expectations & Channels of Communication

- Standardizes communication of core provider expectations across all MCOs
- Increases MCOs' responsiveness to provider complaints by requiring MCOs to maintain a provider manual and to hold provider advisory council meetings composed of a wide array of provider types to gather input and address concerns

Ohio Medicaid Enterprise System (OMES)

What is OMES?

OMES will be the **modernized replacement** of most functionalities in the Medicaid Information Technology System (MITS) and other supporting systems. OMES is made up of all the systems that are used in the delivery of Medicaid services.

How is OMES related to ODM's Strategic Initiatives?

OMES encapsulates **new modules for conducting business.** Some of ODM's strategic initiatives, including Provider Network Management (PNM) and Single Pharmacy Benefit Manager (SPBM), are modules within OMES.

Note: After December 1, 2022, providers will no longer use MITS

How does this change benefit Ohio Medicaid providers?

This transition will reduce administrative burden for providers and enable providers to focus on the more meaningful and important work of providing care to members. With these changes, the OMES serves as a single point of entry for all provider credentialing, claims, prior authorization requests, and member eligibility requests.

- Creating a **single credentialing process**, rather than providers having to be credentialed separately for each managed care entity (MCE) with which they contract.
- **Minimizing** missing claims, delays in claims submission, and delayed payments.
- Making the claims, prior authorization, and member eligibility request process more **transparent** and **efficient** by limiting submission and communication of status to one single portal regardless of the MCE involved. Paper submissions, fax, and/or submissions to multiple MCE portals are no longer allowed.
- Enabling **increased ODM oversight** of MCEs and ability to identify and address trends by providing ODM with consistent access to claims and prior authorization request data.

Increase Program Transparency and Accountability

Increase Program Transparency and Accountability

The MCO's population health approach must include[…] optimizing coordination and collaboration across the system through a systematic and systemic use of information to ensure consistency in coverage and tailored approaches to meeting member needs. [In addition] a statewide SPBM is responsible for providing and managing pharmacy benefits for all individuals.

Key Changes Included in the Future Managed Care Provider Agreement

Model Agreements	Staffing Requirements	Delegated Administrated Services	ODM Access to MCO's Systems & Data	Compliance Actions
• Creates greater consistency of expectations by requiring MCOs to work with ODM, OhioRISE, SPBM, and other MCOs to develop model agreements that define respective responsibilities, data and information exchange requirements, confidentiality / privacy standards, and communication mechanisms	• Ensures that MCOs' key staff have the capabilities, availability, and Ohio-specific focus necessary to fulfill the requirements under the provider agreement by requiring greater number of staff, with specificity of minimum qualifications, dedication level, and local presence	• Ensures MCOs perform due diligence to ensure First Tier, Downstream, and Related Entity (FDRs) are capable of performing delegated functions • Explicitly requires MCOs to monitor and oversee FDR performance and to keep ODM apprised of FDR performance concerns	• Expands the state's access to MCO data by requiring submission to ODM of MCO's own data and integrated data from various sources within the MCO and outside entities including subcontractors, ODM, SPBM, and OhioRISE • Strengthened requirements for timely submission of encounter data	• Eliminates "point system" and refundable sanctions and creates a full range of compliance actions including financial sanctions • Provides authorities for ODM to take compliance actions under the provider agreement for failure to comply with requirements and/or state and federal requirements

MCO Care Guide+ and Care Manager+

Member Engagement

Identifies healthcare needs & supports engagement with existing and future care relationships

Member Care Monitoring

Ensures care coordination needs are met & reviews data indicators to inform the level and type of care coordination needed by the member

Partnership Development

Develops partnerships with other organizations, entities, and people that are supporting the member in obtaining services and addressing healthcare needs

Partnership Identification

Identifies existing and future care relationships across programs including CCEs, OhioRISE, and CMEs to streamline services

Performs or coordinates care coordination activities with CCEs, OhioRISE, and CMEs

A Changing Landscape

Reactive Approach: Intervention

This intervention-based approach focused on members with the most complex needs, requiring enrollment in care management to receive individualized unique services.

Care coordination has largely been separated from or loosely connected to community-based care coordination structures.

This increases the risk for the following:

- Duplication of Care Managers
- Assessment fatigue
- Duplication of Care Plans
- Outreach Fatigue to providers
- Inefficient communication, including multiple touch points

Proactive Approach: Coordinated

All members need access to connected customer service and navigation assistance, even if not "enrolled in care management." This new MCO "Guide" role will provide time-limited help to get people what they need one-time or through short-term services.

The MCO will act as the lead care coordinator (care manager) for certain individuals and specific populations when a designated CCE is not available OR does not meet the individual's needs.

MCOs will support ODM-designated Care Coordination Entities (CCEs) that provide community-based coordination to specific populations of individuals served by our program.

Care Coordination Continuum

Care Guide and Care Guide +

EVENT-DRIVEN COORDINATION

Member needs short-term or a one-time service, had a recent visit to the emergency department or hospitalization, needs coordination to primary care services

QUALIFICATIONS

Experience in care coordination for a minimum of 1 year & has knowledge of internal MCO processes & procedures

Care Guides must be representative and reflect the community of the populations being served

Care Manager and Care Manager +

TREATMENT-DRIVEN COORDINATION

Member has more comprehensive needs that require long-term goal setting, a health care team of specialists, or is diagnosed with a new condition

QUALIFICATIONS

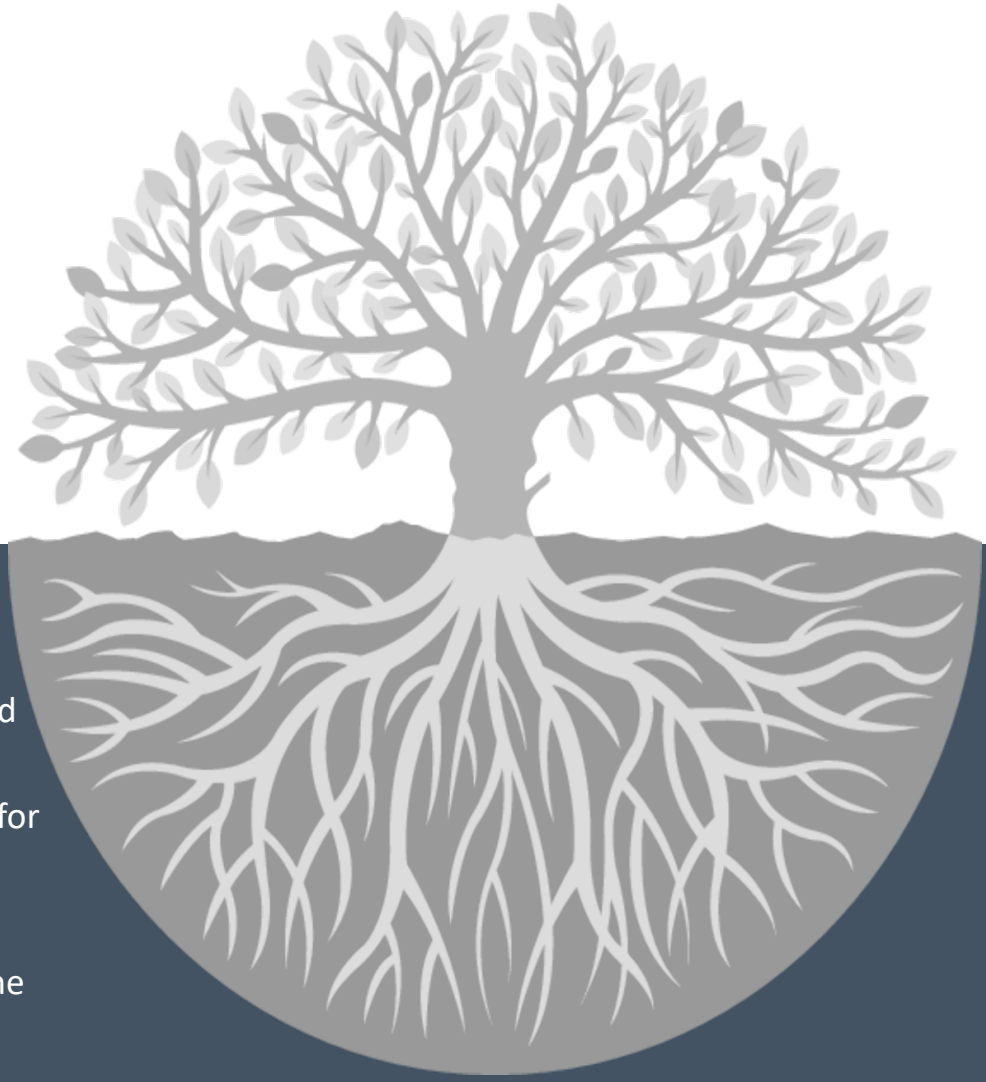
Must be licensed (RN, LSW, LISW, LPC, LPCC, LPCC-S) & has knowledge of internal MCO processes & procedures

Must offer/assign a care manager to a member with long-term care coordination needs, when the level of clinical expertise exceeds Care Guide capabilities, and when indicated by risk stratification

SINGLE POINT OF CONTACT ACROSS THE CARE CONTINUUM

Ohio Medicaid Collective Impact

- Requires managed care organizations (MCOs) to work within the region with other MCOs and community partners to develop approaches to have a collective impact on SDOH.
- MCOs must offer, promote, support, and expand the appropriate and effective use of telehealth., including supporting providers in offering telehealth by providing “how to” guides.
- Provider directories must indicate whether or not a provider offers telehealth, and if so, when telehealth is available.
- MCOs population health approach must include strategies aimed at keeping individuals and their families at the center of all efforts to identify and meet population needs including removing barriers to care through supporting alternative sites and providers of care.



Ohio Medicaid Community Reinvestment

- Ohio Medicaid is investing in local communities by partnering with community organizations and supporting local programs to help tackle various issues.
- The Next Generation managed care organizations (MCOs) must contribute 3% of annual profits for community reinvestment.
- MCOs must not use community reinvestment funding to pay for Medicaid covered services.
- MCOs must work collaboratively with other ODM-contracted MCOs in the region to maximize the collective impact of community reinvestment funding.

Next Generation of MyCare

MyCare Conversion Charter and Principles

Moving to the Next Generation of Managed Care for Individuals Dually Eligible for Medicare and Medicaid

Threshold Decisions

- Plan for Conversion submitted to CMS by October 1, 2022
- Plan for the Next Generation of MyCare aligned with the Next Gen managed care requirements
  - Build on the Next Generation platform
  - Use a similar stakeholder input process as Next Gen
- Address four federally required elements of the plan,
  - including to maximize the integration attained through MyCare & convert to FIDE D-SNP
- Transition no later than 12/31/2025

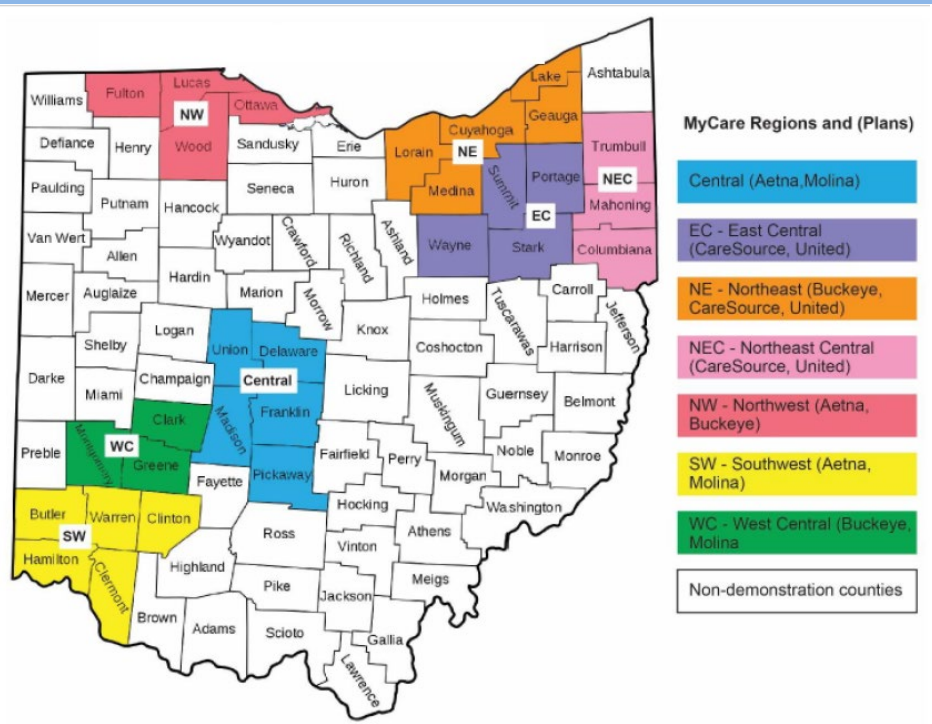


Figure 2. My Care Regions and MMP/AAA Responsibility

MyCare Region	Counties	Area Agency Aging (AAA)	My Care Plans
NW	Fulton, Lucas, Wood, Ottawa	4	Aetna & Buckeye
NE	Lorain, Cuyahoga, Medina, Geauga, Lake	10a	Buckeye, CareSource & United Health Care (UHC)
E Central	Summit, Portage, Stark Wayne	10b	CareSource & UHC
NE Central	Trumbull, Mahoning, Columbiana	11	CareSource & UHC
W Central	Montgomery, Greene, Clark	2	Buckeye & Molina
SW	Butler, Warren, Clinton, Clermont, Hamilton	1	Aetna & Molina
Central	Union, Madison, Franklin, Delaware, Pickaway	6	Aetna & Molina
Non MyCare		3, 5, 7, 8, 9	

Breakdown by Age	
Over 65	72,586
45-64	43,662
Under 45	20,745
	136,993

Breakdown by Race and Ethnicity	
White	74,930
All other race/ethnicity groups	62,063
	136,993

Dual eligible 258,149
Full dual eligible 201,030
- **Enrolled in MyCare 68%**

Breakdown by Type of Member	
Community-Well	90,808
LTSS Waiver	28,635
LTSS NF (≥ 100 days LOS)	17,550
	136,993

Total MyCare Individuals by Age					
Under 45 yrs.		45-64 yrs.		65 yrs. & Over	
268	2%	2,956	17%	14,326	82%
1,025	4%	6,794	24%	20,816	73%
19,452	21%	33,912	37%	37,444	41%
20,745	15%	43,662	32%	72,586	53%

Figure 7A. Individuals with any BH Condition Served by MyCare[1] (7/2022)

		Percent with a current BH Condition			
MyCare Group	**Total Population**	**All Years**	**Under 45 yrs.**	**45-64 yrs.**	**65 yrs. & Over**
NF Residents	17,550	90%	90%	91%	90%
MyCare Waiver	28,635	58%	65%	66%	56%
Community Well	90,808	46%	55%	55%	32%
	136,993	**54%**			
		Percent with an Identified BH Condition			
NF Residents	17,550	95%	94%	97%	95%
MyCare Waiver	28,635	77%	81%	85%	75%
Community Well	90,808	64%	74%	74%	50%
	136,993	**71%**			

Example: 66 % of MyCare individuals between 45-64 yrs… who receive waiver services… had a BH claim in the last 6 months

Most common dx., in order: anxiety, major depressive disorder, schizophrenia, bipolar disorders, PTSD, dementia, and opioid dependence

Maximize integration attained through MyCare & convert to integrated D–SNPs, aligned with the Next Generation mgd care requirements

The Starting Point for Discussion with Stakeholders

The starting point for discussion with stakeholders is as follows. We propose to transition the current MyCare program to a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) model with fully aligned enrollment in a companion Medicaid managed care plan (MMC) subject to the Next Generation program requirements, in the same geographic territories as they exist in MyCare today, serving individuals 21 years of age and older. The benefit package will remain the same, recognizing that each of the MMPs provides value added benefits. The choice to opt in or opt out of Medicare managed care will remain. Self-direction will be streamlined, making it amenable to greater use by individuals. Care coordination has a variety of issues that will be discussed, and modifications considered. For example, the large number of younger individuals who have significant mental health needs, while benefiting from the integration of their care, may require changes to the care coordination model to meet their needs.

Updates on the PNM Module

DRAFT – FOR INTERNAL ODM REFERENCE AND PLANNING ONLY
CONFIDENTIAL, PROPRIETARY, AND PRIVILEGED – MEDICAID PROGRAM PROCUREMENT

What we know and are working to resolve

PNM Administrator/Agent Roles Assignment

The issue

With the statewide requirement for OH|ID single sign on, user roles and assignment to providers could not be converted from MITS to PNM. While the PNM included a "select provider" button that allowed providers a self-service pathway to assign users access to Medicaid IDs (providers), for security reasons that functionality was changed.

What you need to know

The access and assignment process must take place through a phone call to one of our call center agents. Call center agents have been added and troubleshooting tips have been provided to agents to shorten wait times.

Application Pathway

The issue

For Dependently Licensed BH providers we are aware that the PNM displays and requires completion of credentialing information.

What you need to know

A resolution has been identified, is currently in testing and should be implemented by Wednesday, October 26. The screen will still appear because the distinction for dependently licensed and independently licensed is based on the specialty and not the provider type; the screen will be optional for dependently licensed BH providers.

Group Affiliation

The issue

We are aware of an issue experienced when groups and organizations are attempting to update affiliations. In several examples, the list of affiliated providers were not known to that group or organization.

What you need to know

This issue was resolved on October 19. All group and group member affiliations should now be correct.

1903 Revalidation Date Displaying

This issue

This appears to be a conversion issue. ODM and Maximus have identified a resolution that is currently being tested with the other modules. We anticipate implementation next week and providers will see an update to their revalidation dates.

What you need to know

Those that have been paused due to the Public Health Emergency and are not resuming due to recredentialing will be moved to a future date (September 2023), and then realigned over time to allow all providers advance notice of 120 days. Recredentialing dates must remain as there are going to be instances where providers will have less than 120-day notice.

PNM to MITS Connectivity

The issue

PNM to MITS intermittent redirect issues for Claims, PA, member eligibility etc.

What you need to know

Connectivity has been stabilized.

We hear you… and thank you for your continuing feedback

Common questions we have received about the PNM module and centralized credentialing

Backdating Provider Enrollment

Providers have indicated that applicants are not able to back-date their application. This is functioning correctly.
An applicant can mark the request for retroactive enrollment and again indicate so on the attestation pages for provision check. OMD Provider Enrollment specialists will backdate based on the request and after verifying the provider's eligibility dates.

Provider Search Yields no Results

External users can only access the Provider Directory, not the provider search feature. There are known issues with the Provider Directory results and this issue is still being actively researched for resolution.

Issues with PNM Affiliations

ODM will be posting the **CBHC Practitioner Enrollment Files** until the PNM module resolution can be enhanced.

Learning Opportunities

Providers have indicated there are a new terms in the PNM module along with new functionality.
Visit the PNM "Learning" tab – you don't have to log in, just navigate to the PNM site (https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx) to access Quick Reference Guides that include step-by-step instructions. There is a Reference Guide to address self-service functions and how to transfer the administrator role to another member of your organization.

Preparing for the December 1 Launch

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Next Generation Ohio Medicaid Program

1 PROVIDER TRAINING

- **Training sessions** on the Provider Network Management (PNM) module begin October 24 in preparation for changes coming on December 1, 2022. Be on the lookout for a **"Stage 3 101" webinar** prior to the December 1 launch.
- Visit https://managedcare.medicaid.ohio.gov/providers/december+1+launch+training+and+resources for details on the training schedule and how to register

2 COMMUNICATION WITH PROVIDERS

- Visit the **Resources for Providers webpage** at https://managedcare.medicaid.ohio.gov/providers for updates and information.
- Subscribe to receive the **ODM 2022 Press weekly newsletter** containing important updates about the Next Generation program and resources to prepare for December 1, please fill out the Subscribe Form located at https://medicaid.ohio.gov/home/govdelivery-subscribe. Be sure to check the "ODM 2022 Press" box!

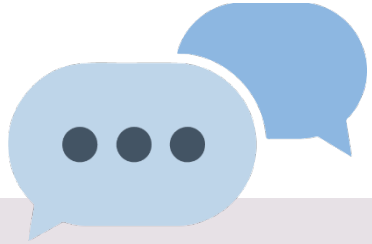
3 PROVIDER FEEDBACK & COLLABORATION

We want to hear from you!

- ODM staff are continuously meeting with provider groups to discuss questions and provider updates.
- Send your questions and feedback to the mailboxes on the following slides – we will get back to you!

Listen to Teresa & Soley

Thank you!



We appreciate your commitment and support for Ohioans in recovery. If you have any questions, please feel free to reach us via email.

Next Generation Ohio Medicaid:
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Fiscal Intermediary (Stage 3 changes related to claims, prior authorizations and other administrative items):
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EDI: EDI-TP-Comments@medicaid.ohio.gov

PNM / Centralized Credentialing: IHD@medicaid.ohio.gov

SPBM / PPAC: MedicaidSPBM@medicaid.ohio.gov

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