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The State of Ohio Medicaid Modernization

Ohio Council Annual Meeting
October 22, 2021

Director Maureen Corcoran
Chief Policy Officer Patrick Beatty
Chief Procurement Officer Jim Tassie
OhioRISE, External Affairs Kelly Smith
Managed Care & Procurement Taskforce Lead Jed Doodan

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Overview: Next Generation of Ohio Medicaid

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Ohio's Next Generation Medicaid Program
Mission Statement

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Our Path Thus Far
Starting with the voice of members and providers

Focusing on the INDIVIDUAL rather than the business of managed care
We began by soliciting input and suggestions from members and providers

119 Medicaid members participated in in-person listening sessions

36 Community partner organizations hosted listening sessions

17 Listening sessions hosted across the state

Requests for Information
Through two RFIs, we…

Received **over 1,000** pieces of feedback from providers, members & advocates

Met with more than 50 providers and provider associations

The Framework for Updating Ohio's Medicaid Managed Care Program

First Generation Program Gaps Feedback highlighted challenges with the current program – many of which the state is constrained in addressing under the current Medicaid Provider Agreement.

Creation of a New Contract New Provider Agreement aimed at addressing these issues and creating the "next generation" of the program.

Changing the Status Quo Creating more levers to position ODM to better adapt & respond to the constantly changing healthcare needs of Ohioans.

Procurement Process Request for Applications (RFA) to solicit responses from MCOs; will ultimately result in the issuance of new MCO contracts.

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DNA of the Next Generation Ohio Medicaid Managed Care Program

Each strategic initiative is needed to realize the full "genetic makeup" of the future program

Managed Care Procurement

The MCO Procurement is the foundational element off which all other strategic initiatives are based. Requirements within the MCO Provider Agreement assume the existence of OhioRISE, SPBM, PNM, Centralized Credentialing and Fiscal Intermediary – and vice versa.

Fiscal Intermediary

Requirements for the Medicaid, OhioRISE and SPBM MCOs to coordinate with and process all clams through the FI are weaved into the MCO Provider Agreement to enable ODM in having increased oversight over MCOs.

SPBM

Requirements of the SPBM MCE are intertwined with the Ohio Medicaid and OhioRISE MCEs providing greater ability to monitor quality, transparency and accountability in the pharmacy program.

OhioRISE

Requirements in the OhioRISE MCE Provider Agreement are intertwined with the Ohio Medicaid MCOs to ensure seamless care coordination and delivery.

PNM / Centralized Credentialing

Requirements for the Medicaid, OhioRISE and SPBM MCEs to accept credentialing via ODM are weaved into the MCO Provider Agreement to ensure reduced administrative burden.

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Medicaid Managed Care

Improve design, delivery and timeliness of care coordination

Goals of Ohio's Future Managed Care Program

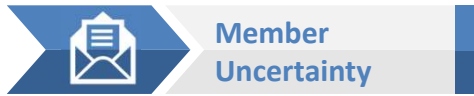| Improve Wellness and Health Outcomes | Emphasize a Personalized Care Experience | Support Providers in Better Patient Care | Improve Care for Children and Adults with Complex Needs | Increase Program Transparency and Accountability |

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Next Generation Go-Live: Why July 1, 2022?

This timeline provides time to educate and support millions of Medicaid members and thousands of providers as they transition to the next generation program.

Member Uncertainty

Allows for time to execute a comprehensive communications campaign to assist members through transition enrollment with the next generation managed care plans, address potential impacts of the Unwinding and meet CMS guidance for annual open enrollment.

Provider Impact

Increases our ability to work closely with vendors, providers and state agency partners to develop and deploy training to assist providers in adapting to new and improved systems and processes. Will allow lead time to build up OhioRISE workforce; collaboration, training and hiring.

Complex Systems

Takes into consideration the complexity of the systems and operational improvements being implemented. Will allow additional time to bring OhioRISE services/supports on line to support counties' Family First Prevention Services Act (FFPSA) implementation starting Oct. 1, 2021.

External Factors

The persistence of the COVID-19 pandemic had an unforeseen impact on Medicaid enrollments, services, programs, and provider communities. This public health emergency has caused a compressed timeframe to assess and redetermine the eligibility for citizens who are enrolled in the program today.
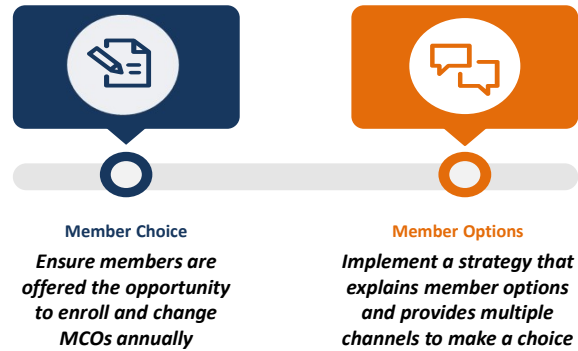
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Open Enrollment

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Annual Open Enrollment Goals and Process

- Ohio Medicaid notification and annual enrollment period will occur between September-December 2021
- Ohio Medicaid members can change MCO with no cause during the annual enrollment period regardless of the option chosen
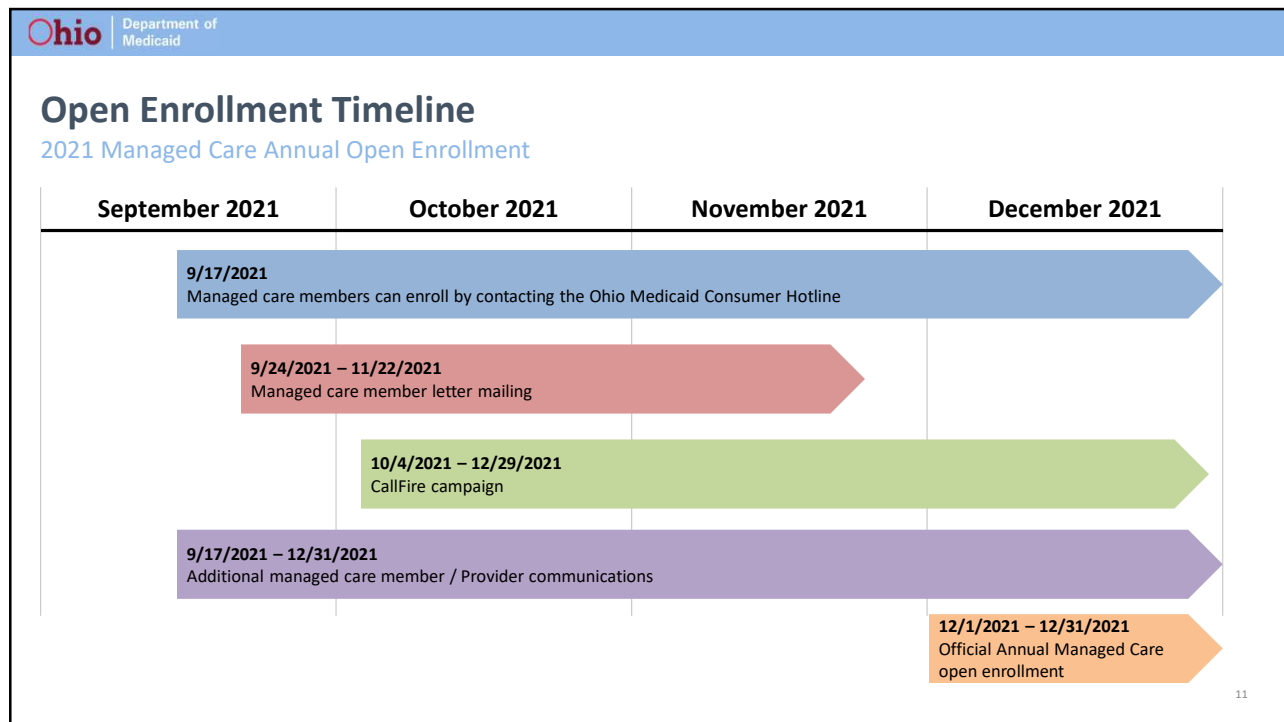
Member Goals

Member Choice

Ensure members are offered the opportunity to enroll and change MCOs annually

Member Options

Implement a strategy that explains member options and provides multiple channels to make a choice

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Communications to Members and Providers

2021 Managed Care Annual Open Enrollment

ODM 2022 Press / Periodical Newsletters
Ohio Medicaid Managed Care Members, Providers, Provider Associations, Advocacy Organizations

Member Letter Mailing
Ohio Medicaid Managed Care Members

Email & FAQs
ODJFDA / Sister State Agencies / Local Boards / PCSAs / DODD Boards / Provider Associations / Advocacy Organizations

Member Call Fire Campaign
Ohio Medicaid Managed Care Members

@OhioMedicaid Twitter
All Stakeholders

Website Messaging
All Stakeholders

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Open Enrollment Timeline
2021 Managed Care Annual Open Enrollment

September 2021	October 2021	November 2021	December 2021

9/17/2021
Managed care members can enroll by contacting the Ohio Medicaid Consumer Hotline

9/24/2021 – 11/22/2021
Managed care member letter mailing

10/4/2021 – 12/29/2021
CallFire campaign

9/17/2021 – 12/31/2021
Additional managed care member / Provider communications

12/1/2021 – 12/31/2021
Official Annual Managed Care open enrollment

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Annual Open Enrollment Process

Members can enroll through contacting the Ohio Medicaid Consumer Hotline or by making changes on the Hotline Member Portal beginning in September. Member choice becomes effective beginning of the next month.

If members do not choose to change, stay with current MCO
If the member does not choose, they'll receive a letter confirming final MCO, which they can change for 90 days.

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MCO Role

2021 Managed Care Annual Open Enrollment

MCOs should continue to provide the highest quality of care to our members

ODM will take the lead for all communications related to Open Enrollment
- MCOs will not be sending out marketing materials to members
- This applies to MyCare plans as well

ODM will give MCOs a banner for their websites

REMEMBER: All member and marketing materials must be submitted to ODM for review and approval
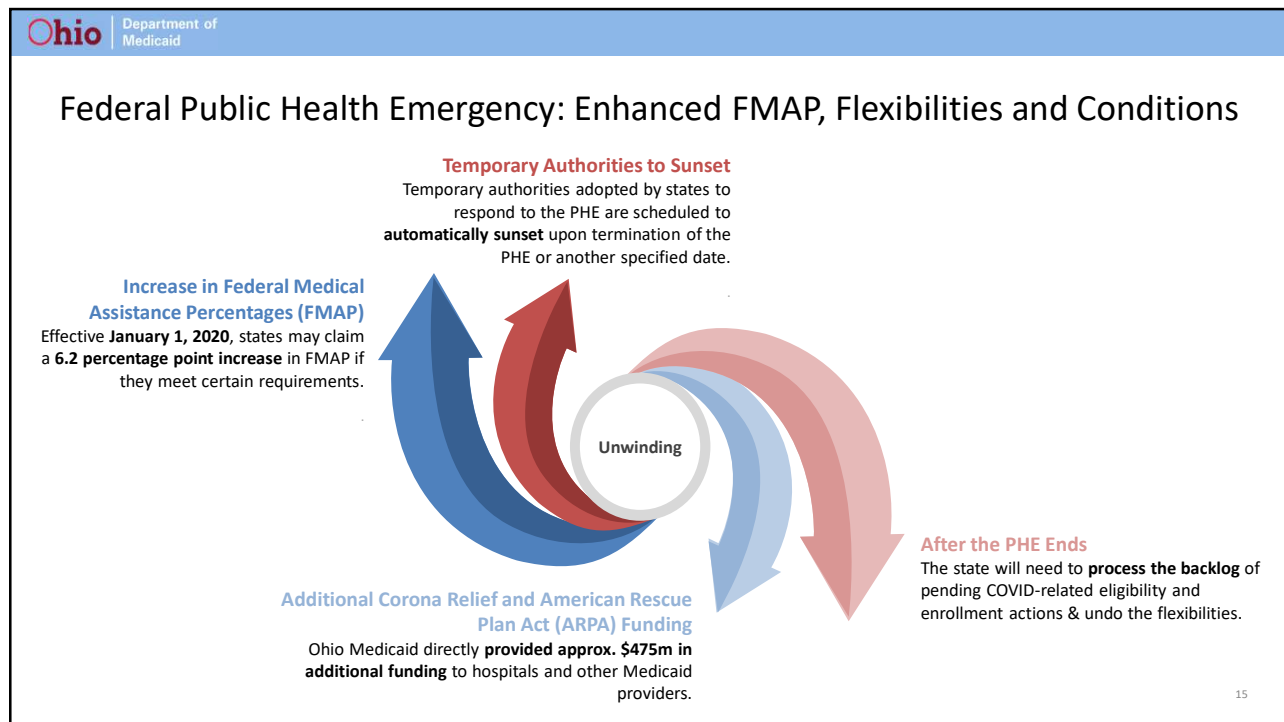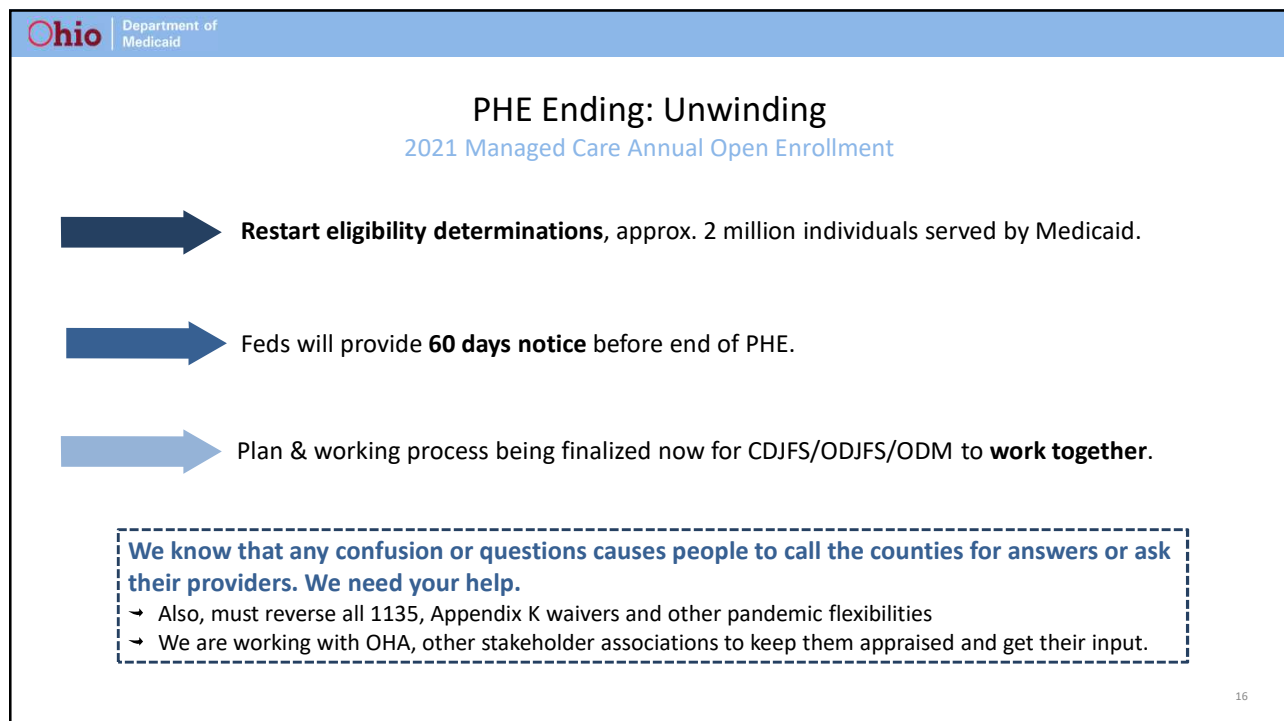
REMEMBER

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Unwinding
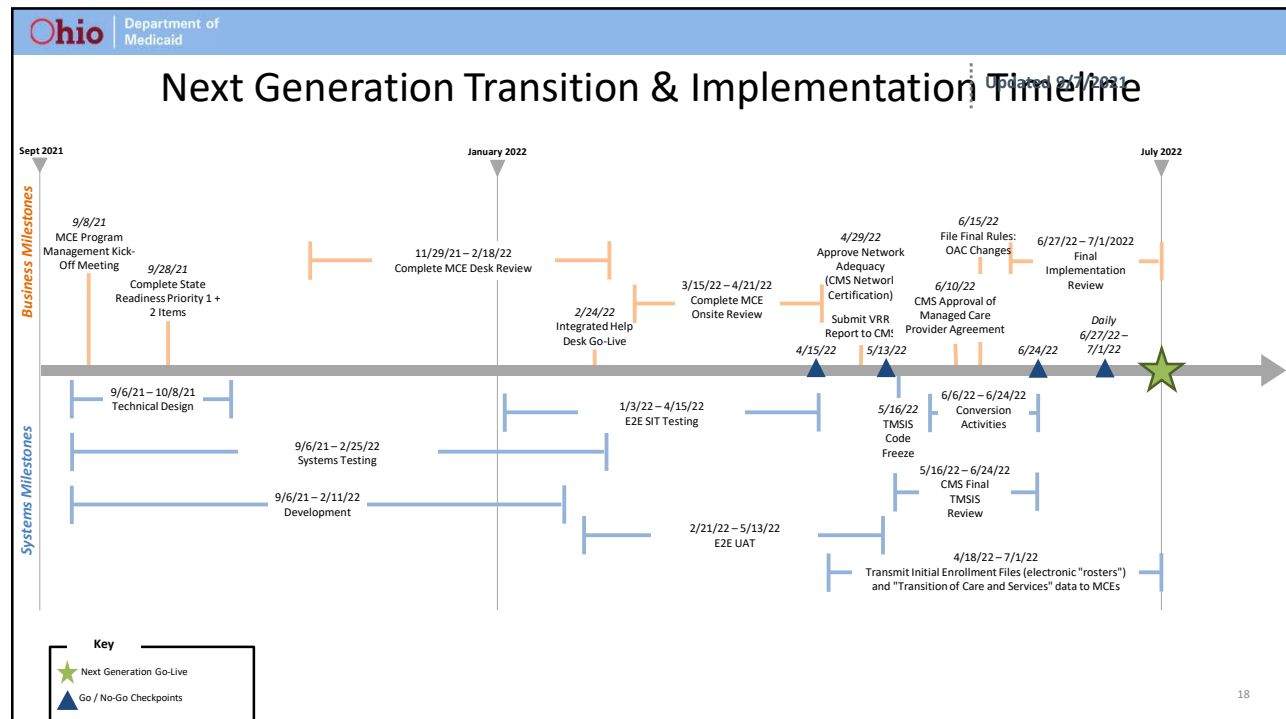# COVID-19 Public Health Emergency (PHE) Declaration

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Federal Public Health Emergency: Enhanced FMAP, Flexibilities and Conditions

Temporary Authorities to Sunset
Temporary authorities adopted by states to respond to the PHE are scheduled to **automatically sunset** upon termination of the PHE or another specified date.

Increase in Federal Medical Assistance Percentages (FMAP)
Effective **January 1, 2020**, states may claim a **6.2 percentage point increase** in FMAP if they meet certain requirements.

Unwinding

After the PHE Ends
The state will need to **process the backlog** of pending COVID-related eligibility and enrollment actions & undo the flexibilities.

Additional Corona Relief and American Rescue Plan Act (ARPA) Funding
Ohio Medicaid directly **provided approx. $475m in additional funding** to hospitals and other Medicaid providers.

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PHE Ending: Unwinding
2021 Managed Care Annual Open Enrollment

Restart eligibility determinations, approx. 2 million individuals served by Medicaid.

Feds will provide **60 days notice** before end of PHE.

Plan & working process being finalized now for CDJFS/ODJFS/ODM to **work together**.

We know that any confusion or questions causes people to call the counties for answers or ask their providers. We need your help.
→ Also, must reverse all 1135, Appendix K waivers and other pandemic flexibilities
→ We are working with OHA, other stakeholder associations to keep them appraised and get their input.

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Member Transition

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Next Generation Transition & Implementation Timeline

Updated 9/2/2021

Sept 2021 — **January 2022** — **July 2022**

Business Milestones

9/8/21 MCE Program Management Kick-Off Meeting

9/28/21 Complete State Readiness Priority 1 + 2 Items

11/29/21 – 2/18/22 Complete MCE Desk Review

2/24/22 Integrated Help Desk Go-Live

3/15/22 – 4/21/22 Complete MCE Onsite Review

4/29/22 Approve Network Adequacy (CMS Network Certification)

Submit VRR Report to CMS

6/15/22 File Final Rules: OAC Changes

6/10/22 CMS Approval of Managed Care Provider Agreement

6/27/22 – 7/1/2022 Final Implementation Review

Daily 6/27/22 – 7/1/22

Systems Milestones

9/6/21 – 10/8/21 Technical Design

9/6/21 – 2/25/22 Systems Testing

9/6/21 – 2/11/22 Development

1/3/22 – 4/15/22 E2E SIT Testing

2/21/22 – 5/13/22 E2E UAT

4/15/22

5/13/22

5/16/22 TMSIS Code Freeze

6/2/22 – 6/24/22 Conversion Activities

5/16/22 – 6/24/22 CMS Final TMSIS Review

6/24/22

7/1/22

4/18/22 – 7/1/22 Transmit Initial Enrollment Files (electronic "rosters") and "Transition of Care and Services" data to MCEs

Key
★ Next Generation Go-Live
▲ Go / No-Go Checkpoints

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Member Engagement & Communications
Next Generation Medicaid Managed Care

Focusing on the INDIVIDUAL rather than the business of managed care
We began by soliciting input and suggestions from members and providers

Requests for Information
Through two RFIs, we…

Received **over 1,000** pieces of feedback from providers, members & advocates

Partnered with 36 community organizations to **host listening sessions in 13 communities** representing a diversity of members and geographies

Met with more than 50 providers and provider associations

The voice of our members is at the core of our vision and design for the next generation Ohio Medicaid program

- ✓ Virtual presentations to advocacy groups, community organizations and County JFS partners
- ✓ Micro Videos
- ✓ Next Generation Managed Care Website – dedicated "Resources for Members" section
- ✓ Member FAQs
- ✓ ODM 2022 Periodical Newsletter
- ✓ MCProcurement@medicaid.ohio.gov mailbox
- ❑ As we approach go-live: Comprehensive member transition enrollment communications and continued listening sessions
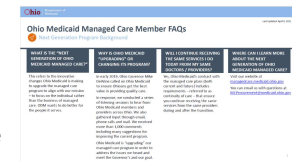
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Provider Engagement & Communications
Next Generation Medicaid Managed Care

Ongoing engagement and communications with providers, provider associations and advocates has remained an important component of ODM's next generation strategic initiative work

- ✓ Virtual presentations to provider associations and organizations
- ✓ Micro Videos
- ✓ Next Generation Managed Care Website – dedicated "Resources for Providers" section
- ✓ ODM 2022 Press Newsletter
- ✓ Provider FAQs
- ✓ Direct emails to communicate "just in time" information
- ✓ MCProcurement@medicaid.ohio.gov mailbox
- ❑ As we approach go-live: Trainings / webinars and videos

Communications Related to Provider Network & MCE Contracting

ODM is directing providers to contact each MCE directly for questions regarding contracting.

As member transition enrollment approaches, ODM's ability to provide members with access to up-to-date MCO provider directories will be critical to supporting member choice & continuity of care.

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Provider Contracting Contact Information

Next Generation of Ohio Medicaid Managed Care

Next Generation MCO Provider Relations Contact Information			
MCO	**Phone Number**	**Web Address**	**Email**
AmeriHealth Caritas Ohio, Inc.	1-833-296-2259	https://www.amerihealthcaritas.com/become-a-provider/join-now-ohio.aspx	ProviderRecruitmentOH@amerihealthcaritas.com
Anthem Blue Cross and Blue Shield	1-833-623-1513	https://www.anthem.com/provider/getting-started/	OHMedicaidProviderQuestions@Anthem.com
CareSource Ohio, Inc.	1-800-488-0134	https://www.caresource.com/oh/providers/education/become-caresource-provider/	Ohio_Provider_Contracting@caresource.com
Humana Health Plan of Ohio, Inc.	1-877-856-5707	Humana.com/HealthyOH	OHMedicaidProviderRelations@humana.com
Molina Healthcare of Ohio, Inc.	1-855- 322-4079	www.molinahealthcare.com	OHContractRequests@MolinaHealthCare.com
UnitedHealthcare Community Plan of Ohio, Inc.	800-600-9007	https://www.uhcprovider.com/en/health-plans-by-state/ohio-health-plans/oh-comm-plan-home.html	N/A
Buckeye Community Health Plan	1-866-246-4356 Ext - 24291	https://www.buckeyehealthplan.com/providers/become-a-provider.html	OHNegotiators@CENTENE.COM

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OhioRISE

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Slide 23

OhioRISE
Resilience through
Integrated Systems and Excellence

A specialized managed care organization (MCO) with expertise in providing services for the most complex multi-system youth

⚕ Specialized MCO
Aetna will serve as the single statewide specialized MCO – to ensure financial incentives and risks are in place to drive appropriate use of high-quality behavioral health services.

🏛 Shared Governance
OhioRISE features multi-agency governance to drive toward improving cross-system outcomes – we all serve many of the same kids and families.

⤳ Coordinated and Integrated Care & Services
OhioRISE brings together local entities, schools, providers, health plans, & families as a part of our approach for improving care for enrolled youth.

📄 Prevent Custody Relinquishment
OhioRISE will utilize a new 1915c waiver to target the most in need and vulnerable families and children to prevent custody relinquishment.

OhioRISE Enrollment
- ✓ Enrolled in Medicaid (managed care or fee for service)
- ✓ Up to age 21
- ✓ In need of significant behavioral health service
- ✓ Require significant functional intervention, as assessed by the Child and Adolescent Needs and Strengths (CANS)
- ✓ Estimate 55-60,000 children & youth by end of year 1

OhioRISE Services
- ✓ All existing behavioral health services – with a few limited exceptions (BH emergency dept.)
- ✓ Intensive and Moderate Care Coordination *NEW*
- ✓ Intensive Home-Based Treatment (IHBT) *ENHANCED*
- ✓ Psychiatric Residential Treatment Facility (PRTF) *NEW*
- ✓ Behavioral health respite *ENHANCED*
- ✓ Flex funds to support implementing a care plan *NEW*
- ✓ 1915(c) waiver that runs through OhioRISE *NEW*
  - • Unique waiver services & eligibility
- ✓ Mobile Response and Stabilization Service (MRSS) *NEW*
  - • Also covered outside of OhioRISE (MCO and FFS)

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Slide 24

OhioRISE Components

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What is a CANS Assessment?

The **Child and Adolescent Needs and Strengths (CANS)** is a functional assessment tool that**:**

- Assesses both child and family **needs and strengths**
- Provides **decision support** to identify appropriate approaches
- Used to make OhioRISE **eligibility determinations**
- Used to support OhioRISE **care planning**
- **QRTP** level of care

There are two types of CANS assessments:

Brief CANS

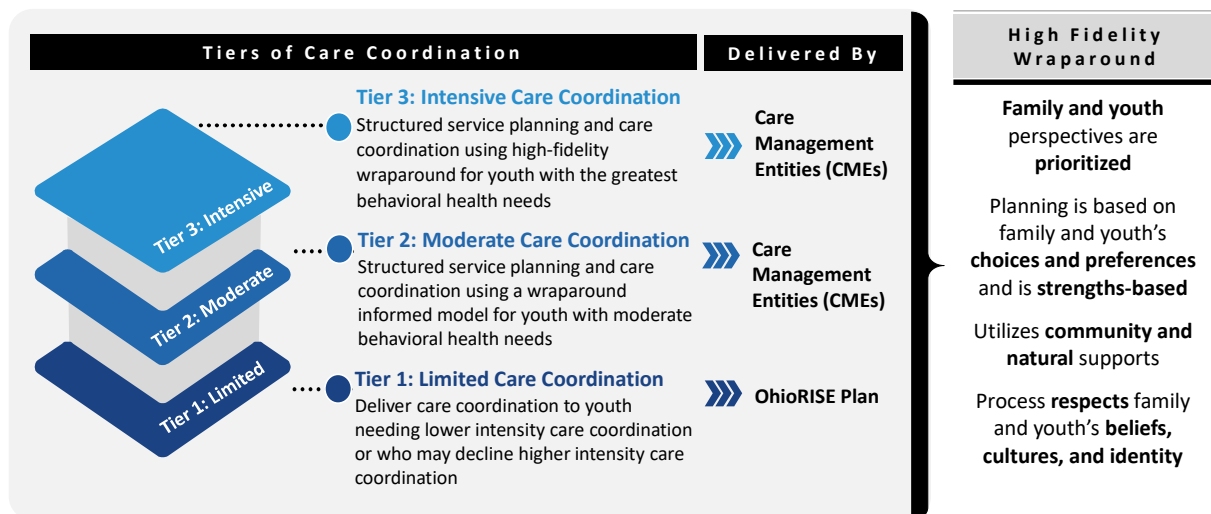**Comprehensive CANS**

Used as an 'initial' assessment…..

….. Used for '**ongoing**' assessments – expands items in Brief CANS to improve care planning and coordination
(Could be used at time of initial assessment if preferred by assessor)

Includes core items to determine eligibility, tier of care coordination, QRTP LOC, recommendations for care

Additional modules are triggered by responses on specific items, such as sexually problematic behavior, runaway, adjustment to trauma

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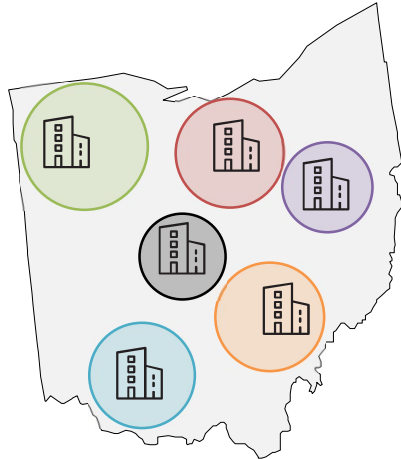
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Care Coordination is Guided by High Fidelity Wraparound Principles

Tiers of Care Coordination	Delivered By	High Fidelity Wraparound

Tier 3: Intensive Care Coordination
Structured service planning and care coordination using high-fidelity wraparound for youth with the greatest behavioral health needs

Tier 3: Intensive

Care Management Entities (CMEs)

Tier 2: Moderate Care Coordination
Structured service planning and care coordination using a wraparound informed model for youth with moderate behavioral health needs

Tier 2: Moderate

Care Management Entities (CMEs)

Tier 1: Limited Care Coordination
Deliver care coordination to youth needing lower intensity care coordination or who may decline higher intensity care coordination

Tier 1: Limited

OhioRISE Plan

Family and youth perspectives are **prioritized**

Planning is based on family and youth's **choices and preferences** and is **strengths-based**

Utilizes **community and natural** supports

Process **respects** family and youth's **beliefs, cultures, and identity**

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What is a Care Management Entity (CME)?

A **Care Management Entity (CME)** is a community-based organization that serves as the "**locus of accountability**" for delivering the Wraparound Model for a catchment (geographic) area of Ohio to serve children and youth enrolled in OhioRISE.

CMEs' Primary Responsibilities:

- **Care Coordination:** provide wraparound-driven care coordination services to OhioRISE enrollees living in the catchment area
- **Community Resource Development:** ground and grow the System of Care within the CME's catchment area

🏢 **Care Management Entity (CME)**   🔴 **CME's Catchment Area**

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CME Catchment Areas

- Each CME is projected to serve approximately 1,000 – 3,000 children during the first year of OhioRISE operations
- Each catchment area will be served by one CME
- CME applicants may submit a proposal to serve more than one catchment area

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OhioRISE Transition

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Goals of the OhioRISE Transition Program

1. **Prepare for a successful full launch of OhioRISE in July 2022, with the rest of the Next Generation of Managed Care program**
- Promote Governor DeWine's Children's Initiative and recognize the Administration's extensive work to better serve Multi-System Youth
- Take action to address Ohio children's urgent behavioral health needs, many of which have been caused or exacerbated by the pandemic
- Actively address workforce challenges within the behavioral health provider network to ensure new OhioRISE services are accessible to children who will enroll in the program in July 2022
- Ensure a strong launch of OhioRISE to support the overall successful implementation of the Next Generation of Managed Care

2. **Support implementation of the Family First Prevention Services Act (FFPSA), which started October 1, 2021**

3. **Recognize and build on the extensive work of the OhioRISE Advisory Council and Workgroups**

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Elements of the OhioRISE Transition Program

Soft-Launch Select Services

- Transition for CANS assessment billing
- Enhance Intensive Home-Based Treatment (IHBT) availability

Workforce & Provider Development

- CANS assessor training and certification
- Select and launch CMEs
- Support and expand MRSS providers
- Technical provider trainings

Youth, Caregiver, & Community Engagement

- Regional community listening sessions
- Engage and train community partners
- Trainings for youth and caregivers

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Enhancing IHBT Availability

- Implementing the enhanced IHBT team structures and updated rates as quickly as possible (Q1 2022) will help to build capacity and serve more children and youth
- Building capacity for IHBT services supports:
  - Increased access to care for children and youth who will benefit from IHBT
  - Growth of IHBT providers (number of providers, geographic range) prior to the launch of OhioRISE
  - Alignment with FFPSA Phase One Prevention Services: Multi Systemic Therapy (MST) and Family Functional Therapy (FFT)

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Workforce and Provider Development

- **Continue CANS assessor training and certification**
- **Select and launch CMEs**
  – Establish infrastructure, hire and train staff
  – Begin Hi-Fi Wrap training, technical assistance, coaching, and certification
  – Conduct community outreach and engagement activities, understand community resources, and begin providing new care coordination services to children
  – Provide early CME care coordination services to priority populations, ex: kids in the custody of local PCSAs who are placed in Qualified Residential Treatment Programs (QRTPs)
- **Support and expand MRSS providers**
  – Support current MRSS providers through July 2022
  – Develop new MRSS providers
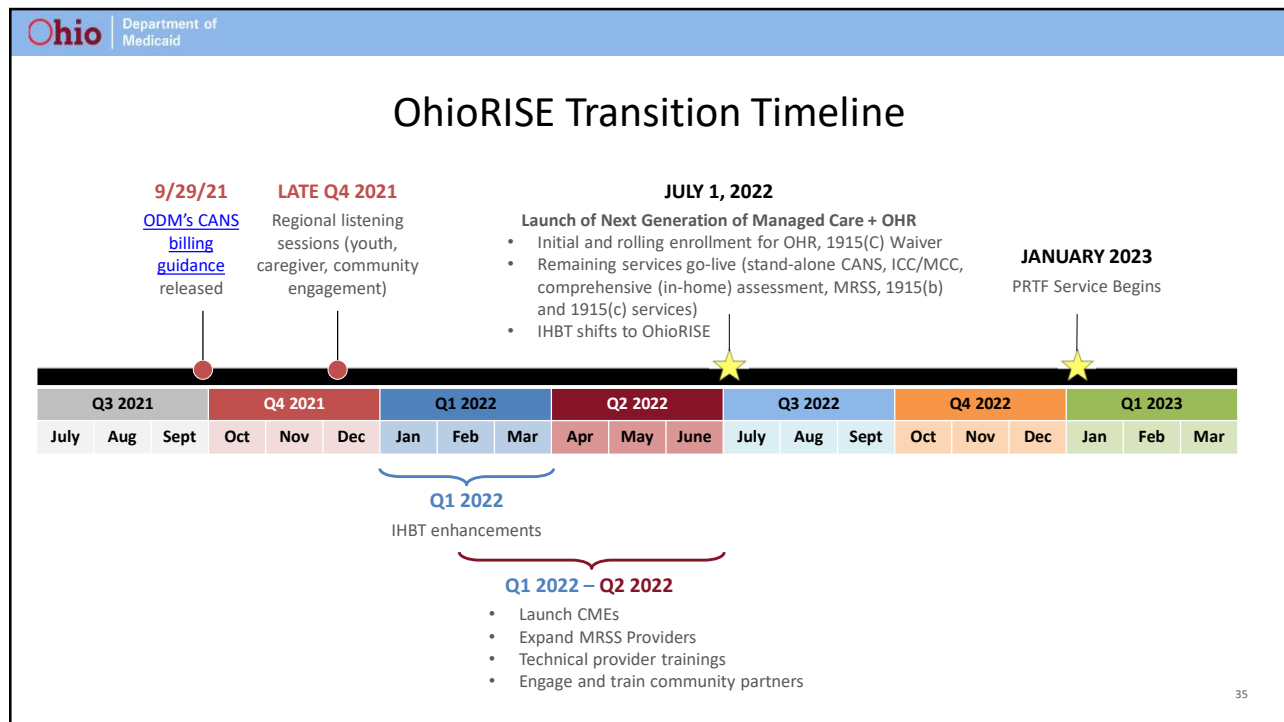- **Technical provider trainings**

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Youth, Caregiver, and Community Engagement

- **Regional community listening sessions**
  – Aetna will host listening sessions later this fall
- **Engage and train community partners**
  – PCSAs, local boards of MHAS and I/DD, judges, physical health providers, etc.
  – Key program elements, roles, responsibilities
  – Opportunities for each type of community partner to support and use OhioRISE
- **Trainings for youth and caregivers**
  – Eligibility and enrollment processes
  – Navigating the OhioRISE system, including child & family team and care planning

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OhioRISE Transition Timeline

9/29/21
ODM's CANS billing guidance released

LATE Q4 2021
Regional listening sessions (youth, caregiver, community engagement)

JULY 1, 2022
Launch of Next Generation of Managed Care + OHR
- Initial and rolling enrollment for OHR, 1915(C) Waiver
- Remaining services go-live (stand-alone CANS, ICC/MCC, comprehensive (in-home) assessment, MRSS, 1915(b) and 1915(c) services)
- IHBT shifts to OhioRISE

JANUARY 2023
PRTF Service Begins

Q3 2021			Q4 2021			Q1 2022			Q2 2022			Q3 2022			Q4 2022			Q1 2023		
July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar

Q1 2022
IHBT enhancements

Q1 2022 – Q2 2022
- Launch CMEs
- Expand MRSS Providers
- Technical provider trainings
- Engage and train community partners

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Provider Network Management

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Provider Network Management (PNM) Module

- **Ohio Medicaid Enterprise System (OMES) PNM Module is part of a larger effort to replace and modernize existing software solutions supporting the Ohio Medicaid Enterprise (OME).**

- **Replaces MITS provider subsystem and the MITS secure portal**
  - Provider enrollment applications
  - Demographic information self-service management
  - Enhanced and more robust provider directory to include MCP affiliation/network

- **Establishes the pathway for ODM's centralized credentialing strategic initiative**

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What is New in the PNM?

- Multiple Medicaid IDs to one NPI

- Ability for providers to view specialties and effective dates

- Provider change or update requests submitted in the system and reviewed in the system – not through an e-mail box or letter (includes CHOPs, name changes, adding specialties etc.)

- Comprehensive provider directory by MCO at the state level

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What is New in the PNM? (cont'd)

- Centralized credentialing - **one application** vs. six

- Text message notification options for providers (opt in/out)

- Online chat feature with a provider enrollment or provider assistance team member (not at go live, but several months later)

- No more paper agreements for LTC facilities – all on-line, no mailing back and forth for signatures

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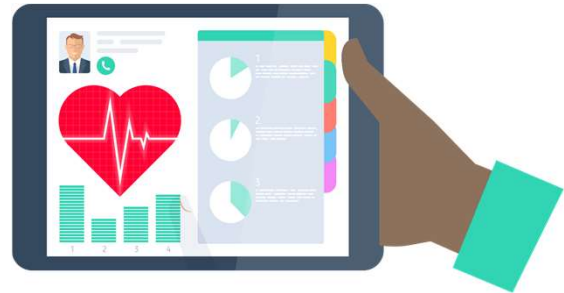
PNM Capabilities

PNM July 1, 2022 Capabilities

- One Front Door for Provider Applications and Credentialing
- One Door for Prior Authorization Submissions (whether PNM or EDI) for all lines of business*
- One Door for Claims Submissions (whether PNM or EDI) for all lines of business*
- One Door for Recipient Eligibility Look-up (whether PNM or EDI or IVR) for all lines of business*
  - Note: this will be basic eligibility for MCO but full eligibility for FFS. The reason is that each MCO may have more than base Medicaid they are providing for members.
- Additional functionality that exists in MITS today that will continue in PNM in the future:
  - Cost Report Submission
  - Ability to upload attachments for Prior Authorizations and Claims

Future PNM Capabilities (Post Go-Live)

- Med Chat
- Ability to print 1099s
- W9 will not have a fillable pdf online until after Go Live
- Ability to have more than one (1) Administrator (MITS only allows one Administrator today)
- New Projects:
  - Doula
  - Baby/Mother Dyad
  - Welcome Home Postpartum Visits
  - Cost avoidance for Medicaid Opioid Treatment Programs
  - Add new Provider type to support new service under the SRS program
  - ABA for additional provider types
  - Timely Claim Filing Edit Modification
  - Aligning Coverage of FQHC/RHC BH Services w/BH Redesign
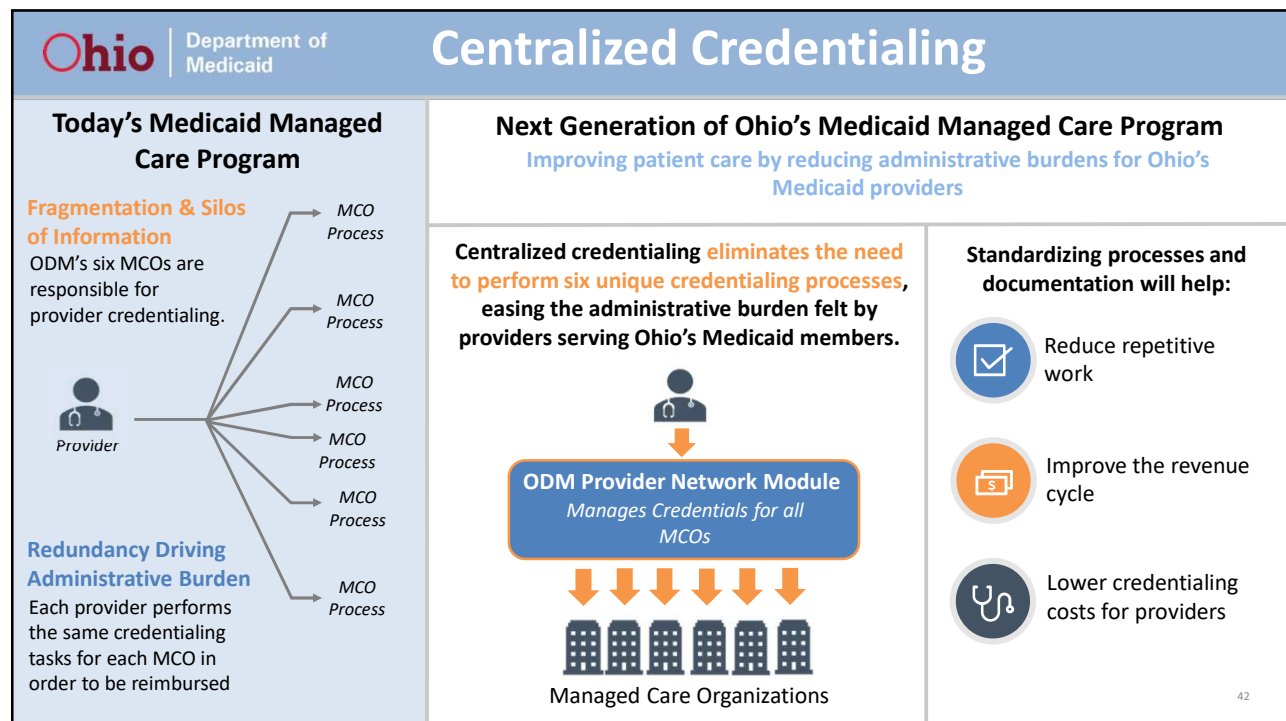- Allowing FQHCs/RHCs to Submit All Claims Under One NPI

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Centralized Credentialing

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Centralized Credentialing

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Today's Medicaid Managed Care Program

Fragmentation & Silos of Information
ODM's six MCOs are responsible for provider credentialing.

Provider

MCO Process

MCO Process

MCO Process

MCO Process

MCO Process

MCO Process

Redundancy Driving Administrative Burden
Each provider performs the same credentialing tasks for each MCO in order to be reimbursed

Next Generation of Ohio's Medicaid Managed Care Program
Improving patient care by reducing administrative burdens for Ohio's Medicaid providers

Centralized credentialing **eliminates the need to perform six unique credentialing processes**, easing the administrative burden felt by providers serving Ohio's Medicaid members.

ODM Provider Network Module
Manages Credentials for all MCOs

Managed Care Organizations

Standardizing processes and documentation will help:

Reduce repetitive work

Improve the revenue cycle

Lower credentialing costs for providers

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Centralized Credentialing

- Individual providers who require credentialing – only those providers who can practice independently under state law
- Facilities that require credentialing
- Differences between enrollment and credentialing
- CVO model – transition between ODM and CVO utilizing PNM
- Data transition from the plans – timelines, data received, benefits to the provider

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Primary Source Verification Requirements

- Active and valid license
- DEA certificate
- Education/training
- Board certification
- Malpractice insurance
- CAQH Application
- 5 Years of work history
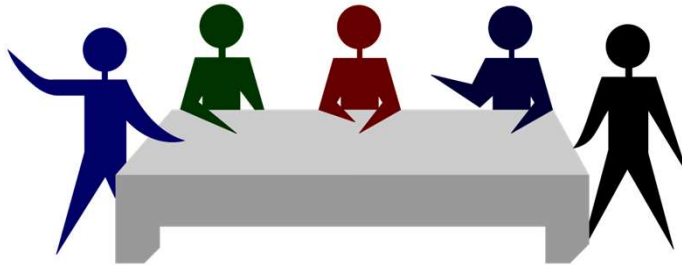- NPDB report
- Hospital privileges (if applicable)

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Credentialing Committee

- Composition – community-based providers, MCP representatives, CVO representatives

- Roles and responsibilities

- What constitutes an "adverse" file

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Delegate at the State

- Delegates will be utilized for the program

- Delegates in process represent over 20,000 Ohio Providers/19 systems

- Exploring automated upload – demographic updates

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Fiscal Intermediary

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Background

The Ohio Medicaid Enterprise System (OMES) FI Module is part of a larger effort to replace and modernize existing software solutions supporting the Ohio Medicaid Enterprise (OME).

Approach:	Focus:
The OMES program approach is to implement Commercial off the Shelf (COTS) modules focused on specific business functions using a systems integrator to facilitate data sharing across modules.	The FI Module focuses on the systems and operations capabilities needed for claims and prior authorization processing, MC capitation, and Ohio Department of Medicaid (ODM) financial management.

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Fiscal Intermediary (FI)

Today's Ohio Medicaid Program

Provider claims and authorization requests are handled by each Managed Care Organization (MCO) and data is self-reported to Ohio Medicaid, at times several months after the service or request took place.

- Providers experience frustrations interfacing with multiple MCOs, sometimes leading to payment delays

- Grievances and disputes between providers and MCOs are challenging to mediate as data is not consistent or readily available

- ODM is constrained in providing the Ohio Legislature and the public with timely data as it can often take over 6 months for MCO data to be transmitted to the state

The Future Ohio Medicaid Program

Easing Administrative Burden

- The FI will serve as a single point of entry for all provider claims and prior authorization requests
- Minimizes missing claims or delays in claim submission

Transparency

- ODM will have access to consistent and complete claims and authorization data, enabling increased oversight over MCOs
- Claims and payment trends can be identified in a more timely manner (weeks instead of months)

Efficiency

- The FI will facilitate processing of and transitioning claims and requests to Ohio Medicaid's future MCOs as well as receive updates back from those organizations and be able to convey these to providers
- Central intake of claims minimizes MCOs' ability to delay payment

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Fiscal Intermediary Functions

- **Processing of Fee-For-Service (FFS) claims and Prior Authorization Requests**

- **Routing of Managed Care Claims and Prior Authorization Requests**

- **Receipt and Validation of Encounters Received from Managed Care Organizations (MCOs) Resulting from their Claims Processing**

- **Data Exchange with MCOs**

- **Payment of FFS Providers**

- **Payment of Per Member / Per Month Capitation Rates to MCOs**

- **Other Payments as Directed by the State**

- **Management of Financial Data for Medicaid and Related Programs Operated by the OMES**

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Questions and Closing Remarks

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For More Information

———— Contact Us ————

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Centralized Credentialing – Credentialing@medicaid.ohio.gov

Learn more about the Next Generation Program

Managed Care Procurement Website	ODM 2022 Press ODM 2022 Periodical

Frequently Asked Questions (FAQs):
Ohio Medicaid Managed Care Member Care FAQs
OhioRISE FAQs
OhioRISE Member Care FAQs
Centralized Credentialing FAQs
Fiscal Intermediary FAQs

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