OHIO DEPARTMENT OF MEDICAID JMOC DELIVERABLES MARCH 8, 2024

To: Senator Mark Romanchuk, Chairman, Joint Medicaid Oversight Committee
Director Jada Brady, Joint Medicaid Oversight Committee
From: Steven Stearmer, ODM
Date: March 13, 2024
CC: Eric Vinyard, ODM
Brooke O'Neill, ODM

Mr. Chairman and Director,

We appreciate the opportunity to respond to the issues presented to the Ohio Department of Medicaid (ODM) by stakeholders at the JMOC Stakeholder meeting on February 15, 2024. Specific concerns that were identified have been identified and answered below. Concerns that were shared between stakeholders have been grouped together and answered as a single item. We hope this information provides additional clarity and surety that ODM takes these concerns seriously and is expeditiously working to address them.

Fairfield Co. ADAMH Board Concerns

We are truncating issues from Fairfield ADAMH Board as a detailed response was already provided. Updates have been included below. While not comprehensive, there are five main issues identified.

<u>Issue 1: Missing Eligibility Responses</u>
Key Details: The Fairfield ADAMH Board provided some additional files that did not have a returned eligibility response.
ODM Review: We discovered that the returned file failed the HIPAA compliance check and was sent back for reprocessing.
ODM Action: We have been performing forensic investigations into the system's performance and are investigating why non-compliant data were generated, and why communications about the process were not sent back to the requestor.

<u>Issue 2: Changes to the Eligibility Query Process</u>
Key Details: Changes to the eligibility responses process remain a matter of debate between the Board and ODM.
ODM Review: N/A
ODM Action: We are working with our vendor to see if there is anything that can be done to relax the current parameters and still protect our member's data.

Issue 3: Trading Partner Connections
Key Details: New Trading Partner (TP) credentials were not being issued.
ODM Review: Updates on the resumption of issuing additional credentials were not communicated on the website.
ODM Action: The ability to add additional TPs has been restored as of 3/1/2024; onboarding three new TPs for the Boards has started. The approval process is being routed for signatures and is testing with the boards is expected to begin around 3/14/2024. ODM is in the process of updating our webpage to reflect this update.

Issue 4: Data Access
Key Details: ADAMH Boards want more access to Medicaid data.
ODM Review: ADAMH boards are authorized to view Medicaid eligibility to coordinate payments. Because the ADAMH boards are no longer paying for Medicaid services utilized by a Medicaid eligible person, and do not provide services directly, Medicaid is no longer authorized to transmit all claims related data to them.
ODM Action: ODM has been engaged with the Boards on this issue for several years. It is not related to the new OMES system or its implementation. MHAS has the lead responsibility for data sharing discussions related to the ADAMH boards' responsibility for community planning.

Issue 5: System Updates and Communications
Key Details: Stakeholders are looking for more proactive information sharing from ODM including how systems issues are identified and prioritized and for scheduled updates.
ODM Review: Defects and projects are identified by ODM staff or through the IHD call centers and added to the OMES error tracking system for evaluation. Any confirmed defect is scheduled for resolution based on implementation efficiency and magnitude of its system impact. Fixes are bundled together for cost effectiveness and to minimize disruptions to the OMES system.
ODM Action: A new, in-house CPSE Report has been compiled and posted to our website to provide additional clarity around known error codes and system issues and to share what is being done to address each item. Information on when a fix for these errors is included. Current and archived information on system news is also available through the landing page. On 3/1/2024, ODM also issued a limited exemption to the timely filing requirement for fee-for-service and managed care claims submitted through trading partners via the Electronic Data Interchange (EDI) and subsequently processed in the Fiscal Intermediary. More information on the announcement can be found here.

Ohio State Medical Association & Ohio Hospital Association Concerns

Concerns of both the Ohio State Medical Association (OSMA) and Ohio Hospital Association (OHA) have been combined as they are similar or directly overlap.

Issue 1: Generic Claim Denial CO-AI
Key Details: Medicaid Fee-for-Service (FFS) claims are denying with the generic error code CO-AI.
ODM Review: ODM is aware of ongoing systems errors.
ODM Action: The new CPSE Report can provide additional clarity around known error codes and system issues. ODM will create a project that will be recorded on the CPSE for tracking and delivery updates.

Issue 2: OMES Useability Challenges
Key Details: Electronic Medicaid FFS claims can no longer be viewed, edited, or have attachments via the MITS portal; supporting documents with a claim cannot be sent. A claim's status cannot be verified electronically.
ODM Review: This specific issue is tied to the exitance of two claims processing engines and will be solved when the old MITS system is retired. ODM expects this to be complete no later than 7/1/2024 based on the required testing and training that needs to take place.
ODM Action: An official announcement should be made in the next few weeks and will include both the expected go-live date and when the training on the new system will begin prior to go-live.

Issue 3: Crossover Claim Delays
Key Details: Crossover claims are being delayed—sometimes by weeks or months.
ODM Review: Two key issues impact the crossover claim market: one is related to provider enrollment and the other concerns affiliation checks. Providers have always been required to register with ODM to do business with Ohio and provide services to Medicaid members. In the old system, the billing provider and primary rendering provider were the only ones required to be known in order to submit a claim through the front door. The new system more fully implements Medicaid rules and checks for all providers to be known to the system and for the appropriate contractual affiliations.
ODM Action: Some of these requirements are system driven and some of them are policy driven. We are working with the vendor to find ways to potentially modify the program to meet Medicaid policy while relaxing the level of scrutiny applied to every provider and relationship on a claim. While we are working on this balance, we would encourage all providers doing business with the state (providing services to Medicaid members)—including those members covered by the ODM managed care plans—to enroll with the PNM and to keep their affiliation and contracts up to date. This is the best way to make sure that claims are processed through the system while we work on fine tuning the system settings.

Issue 4: Information Disparities & Variability Among Modules
Key Details: MCOs appear to be missing information or updates are not occurring as expected between system components along with enrollment and affiliation challenges.
ODM Review: It may take up to 48 hours for all data changes to be ingested into a plan's systems which may falsely appear to be "lost" or "randomly" changed data. Plans are

currently using a mix of their own data and the Provider Master File (PMF) data to accept and pay as many claims as possible. The PMF file delivery time is inconsistent and invalid affiliations are sporadically occurring. Most other issues cited appear to be related to the timing for data to synchronize.
ODM Action: ODM has instructed the plans to ingest the PMF file daily and has confirmed that they are doing so. Once ingested, it still takes several days for the data to flow into their system, but we are working with them to speed up this process. ODM is reviewing the edits to find efficiencies in the process and to help the plans use the PMF data more accurately. We are also working with the EDI and the plans to coordinate the best place to catch affiliation mismatches.

Issue 5: Provider Network Management (PNM) Module
Key Details: Only one group/organization can maintain a Provider's profile as an "administrator"; practitioner affiliations also cannot be based on group.
ODM Review: The provider is expected to determine their administrative permissions based on their own employment arrangements. However, different personnel can be granted different levels of control over a provider's profile with the proper permission to ensure information can be entered and retrieved by the appropriate parties. Practitioner affiliation is still limited to the site level.
ODM Action: Trainings for administrators and providers on the PNM can be found on our website. PNM Quick Reference Guides may be found on the "Learning" tab on the PNM landing page. A fix to permit practitioner affiliation at the group level is in process.

Issue 6: Managed Care Plans Not Following ODM Guidance
Key Details: Managed Care Plans are not always following ODM guidance for claims processing.
ODM Review: To some extent, plans are allowed to create their own rules regarding the use of modifiers and other data on an EDI transaction. However, the payers may have different rules on how they use these data elements.
ODM Action:
Prior to the go-live of the new system, ODM instituted a standardized companion guide which governs how data are to be transmitted by the plans and established data requirements for the 'single front door'. For example, rather than allowing each plan to have their own member identification number, a single member identification number was implemented. If a member changes from one plan to another, their identification number remains the same. Requirements were also established related to the X-12 standards regarding the processing of data. Plans have been instructed that if the data are provided on the EDI transaction—regardless of where it is located on the transaction—that they are to process these correct data elements as if it had been submitted in the plan's desired location. ODM is continuing to work to improve the consistency and simplicity for providers balanced with the plans' need for 'differences' from a standard practice.