Questions	ODM Managed Care	ODM MyCare	OHCA Comments
How much time do the plans have to pay claims? What is an acceptable prompt payment period to pay a claim from submission to payment?	Appendix J, Pg. 123 4. Prompt Pay Requirements. In accordance with 42 CFR 447.46, the MCP shall pay 90% of all submitted clean claims within 30 calendar days of the date of receipt and 99% of such claims within 90 calendar days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule mutually agreed upon and described in their contract. The date of receipt is the date the MCP receives the claim, as indicated by its date stamp on the claim.	Same for MyCare	
What is the average time it takes to pay a claim?	This could vary by Plan, and whether or not it was a clean claim. However, there are Managed Care Dashboards on the Medicaid web page that provides the percentage of clean claims paid or denied with the 30 days. https://medicaid.ohio.gov/Managed-Care/Dashboards	Same for MyCare	
What information is required to adjudicate a claim?	MCPs are not required to use the same coding systems as Medicaid Fee-For-Service (FFS), though all plans must use HIPAA compliant coding and transactions/ files for billing. Please contact each Plan for their specific billing requirements. https://medicaid.ohio.gov/provider/ManagedCare#1900231-provider-resources	Same for MyCare	
What constitutes a clean claim?	Appendix J, Pg. 124 4. Prompt Pay Requirements. A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party. 42 CFR 447.45 states clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.	Same for MyCare	The issue is that the information required to constitute a clean claim varies from plan to plan. Even the definitions of specific items within a claim form, such as providcer number, vary from plan to plan. It would be easier if the ODM billing instructions were applied uniformly to all plans, including definitions, with the exception of member ID number
What requirements exist for the plans to notify providers in policy changes that may impact claim submission and payment?	Appendix C, Pg. 44 36. Health Information System Requirements. b. Electronic Data Interchange (EDI), Claims Adjudication and Payment Processing Requirements. x. The MCP is required to give a 30 calendar day advance notice to providers of any new edits or system changes related to claims adjudication or payments processing.	Same for MyCare	This is not happening. I sent you an example from Caresource for an administrative change effective January 1st that was updated in the provider manual but providers were not notified.
What guidance is required to be given to providers on claim submission and plan policies?	OAC 5160-26-05.1 Managed health care programs: provider services: (A) MCPs must provide the following written information to their contracting providers: (5)The MCP's process and requirements for the submission of claims and the appeal of denied claims. Appendix C, Pg 48 41. Information Required for MCP Websites. b. The MCP provider website shall also include, at a minimum, the following information which shall be accessible to providers and the general public without any log-in restrictions: iii. The **MCP's provider manual including the MCP's claims submission process,** as well as a list of services requiring PA, recent newsletters, and announcements.	Same for MyCare	
When a claim is denied, what information should be given to the provider about why the claim was denied?	Appendix C, Pg. 41 The MCP shall notify providers who have submitted claims of claims status (paid denied, and all claims not in a final paid or denied adjudicated status [hereinafter referred to as "pended/suspended"])) within one month of receipt by the MCP or its designee. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly, or more frequent, basis. **(Not in the provider agreement - HIPAA requires standardize code sets to be used with claims submitted electronical data inchange (EDI) that are returned to the provider. These code sets are used nationally across provider payers within the healthcare industry.)**	Same for MyCare	
How do agencies seek reimbursement for claims that were denied because the patient changed plans?	Whatever Plan the member was enrolled with on the date of service, is the Plan that should be billed for services. Per Appendix C, 34biii - Transition of Care Requirements for New Members. The MCP shall honor any prior authorizations approved prior to the member's transition through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with the MCP. 1. The MCP may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCP must render an authorization decision pursuant to OAC rule 5160-26-03.1. 2. The MCP may assist the member to access services through a network provider when any of the following occur a. The member's condition stabilizes and the MCP can ensure no interruption to services; b. The member chooses to change to a network provider; or c. If there are quality concerns identified with the previously authorized provider.	Same for MyCare	

Questions	ODM Managed Care	ODM MyCare	OHCA Comments
How long do agencies have to bill after a date of service?	See tab "Plan Info"	See tab "Plan Info"	
What is the time period allowed before a claim is denied for timely filing?	See tab "Plan Info"	See tab "Plan Info"	
What penalties/consequences exist for plans that do not pay claims for services that were authorized and rendered? Delays in payment above and beyond industry standards	ODM uses a variety of corrective actions or financial sanctions as defined and outlined in Appendix N - Compliance Assessment System. 2. Types of Sanctions/ Remedial Actions b. Financial Sanctions If there are systemic issues causing the Plans to delay payments on claims, or payments are taking longer than 30 days, we would request the providers submit a complaint using the provider portal: https://providercomplaints.ohiomh.com/ProviderComplaintForm.aspx?forceredirect=true ODM requires the MCP to report claims payment systemic errors (CPSE) monthly. With the information the providers submit using the complaint form, we are able to monitor the issue.	Same for MyCare	
What dates should be used for claim appeals processed subject to timely filing requirements?	more clarification, specific examples **(NOTE: I will need to reach out to each of the Plans for this specific questions, or add it as an agenda item to discuss with each of the Plans.)**		
What are the requirements for case managers to respond to authorization requests?	more clarification, specific examples - is this just for MyCare?	Thank you for the feedback. Our managed care plans do have flexibility in how they design their care management approach, including how they operationalize their arrangements with AAAs for waiver service coordination.	Urgency is not referenced in our federal conditions of participation. All home health patients must be started within 48 hours. The state regulation should support the federal requirement, and all home health authorizations should be approved within 48 hours. Please see § 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. (a) Standard: Initial assessment visit. (1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within **48 hours** of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.
What is the time period for which they must respond?	more clarification, specific examples - is this just for MyCare?		
Inconsistent case management structure, waiver signature requirement submissions, and inconsistent methods of handling case manager relationships as it relates to working with county case workers and updating the patient all service plan. a. Dependent on the health plan, and in some cases the case manager, providers are told to go through the Area Agency on Aging Case Managers or the Managed Medicaid plan's case managers to update service plans and complete the waiver signature requirements. In many instances, the AAA case manager is contacted and the provider is told to contact the managed Medicaid plan. There does not seem to be consistency with this.	ODM is open to suggestions on how to make improvements.	

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How much time does a plan have to make an authorization determination? Inconsistent preauthorization requirements or authorization requirements above and beyond industry standards.	MCPs may prior authorization more services, and have different process than fee for service. Either a member or a provider may request coverage for a service through the prior authorization (PA) process. MCPs are required to report information on all PA decisions rendered for their members. This includes PA requests for all services, including requests for services when the MCP is not the primary payer. For standard authorization decisions, plans must either approve or deny the request **within ten calendar days** and this is a standard that the Office of Managed Care would take compliance on if not met (see OAC 5160-26-03.1). Plans must approve or deny pharmacy authorizations within 24 hours for Medicaid managed care or 72 hours for MyCare Ohio. If a PA is denied, the member has the option to appeal to the MCP. Possible reasons why an MCP may deny a request could be due to lack of medical necessity or no medical documentation. Ohio Revised Code 5160.34 (B)(4)(a) also states if the health care provider submits the request forprior authorization electronically as described in divisions (B)(1) and (2) ofthis section, respond to all prior authorization requests **within forty-eighthours for urgent care services**, or ten calendar days for any priorauthorization request that is not for an urgent careservice, of the time the request is received by the department or its designee. Division (B)(4) of thissection does not apply to emergency services. (See tab 'Plan Info' for specific prior authorization requirments for each Plan)	Same for MyCare	Please see § 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. (a) Standard: Initial assessment visit. (1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within **48 hours** of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.
Under what circumstances an authorization should be expedited?	The Plans should expedite prior authorizations when care is urgent. (see response above) Per Ohio Revised Code 5160.34 (A)(5) urgent care services means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following: (a)Could seriously jeopardize the life, health, or safety of the recipient or others due to the recipient's psychological state; (b)In the opinion of a practitioner with knowledge of the recipient's medical orbehavioral condition, would subject the recipient to adverse healthconsequences without the care or treatment that is the subject of the request.	Same for MyCare	
Delays in authorization approval timeframes resulting in delayed start of care or resumption of services. Systematic downgrading or urgent requests to non-urgent status at the discretion of utilization management teams	MCPs are required to report information on all prior authorization (PA) decisions rendered for their members. This includes PA requests for all services, including requests for services when the MCP is not the primary payer. For standard authorization decisions, plans must either approve or deny the request within ten calendar days and this is a standard that the Office of Managed Care would take compliance on if not met (see Ohio Administrative Code rule 5160-26-03.1 Managed health care programs: primary care and utilization management.) If there are delays/ issues causing the Plans to take longer than 10 days, we would request the providers submit a complaint using the provider portal: https://providercomplaints.ohiomh.com/ProviderComplaintForm.aspx?forceredirect=true	Same for MyCare	
What obligations do the plans have for exceeding authorization denials?	Need more information? **(NOTE - will need more time to address this question.)**		
What requirements exist for the plans to contract with home health agencies?	Appendix H, starting pg. 93 1. Federal Access Standards. The MCP shall provide or arrange for the delivery of all medically necessary, Medicaid-covered health services in a timely manner, and ensure compliance with federally defined provider panel access standards as required by 42 CFR 438.206. However, there aren't specific provider/ panel requirements for home health agencies.	There are no specific network panel standards for Medicare-Certified home health agencies who provide home health aide and nursing services. There are also no specific network panel standards for private duty nursing services. ODM does have MyCare regional network adequacy standards for waiver personal care and nursing. From an operational-perspective, we require all managed care plans to assure all services mandated in the provider agreement, including home health and private duty nursing, are available to all members just as we make available in FFS. This is outlined in Appendix G, 1.	
How is it determined that a home health agency is “in-network”?	Home Health Agency that enters into a contract with a MCP is considered "in-network". If HHA would like to become in-network with the MCP, they would need to contract with the specific Plan.	Same for MyCare	

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What data are the plans required submitting to prove network adequacy?	Appendix H, starting pg. 93 1.c. In order to demonstrate adequate provider panel capacity and services, 42 CFR 438.206 and 438.207 stipulates that the MCP shall submit documentation to the Ohio Department of Medicaid (ODM), in a format specified by ODM, that demonstrates it offers an appropriate range of preventive, primary care, behavioral health, family planning, and specialty services adequate for the anticipated number of members in the service area, while maintaining a provider panel sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area. This documentation of assurance of adequate capacity and services shall be submitted to ODM no less frequently than at the time the MCP enters into a contract with ODM; at any time there is a significant change (as defined by ODM) in the MCPs operation that would affect adequate capacity and services (including changes in service benefits, geographic service or payments); on an annual basis; and at any time there is enrollment of a new population in the MCP.	There are no specific network panel standards for Medicare-Certified home health agencies who provide home health aide and nursing services. There are also no specific network panel standards for private duty nursing services. ODM does have MyCare regional network adequacy standards for waiver personal care and nursing. From an operational-perspective, we require all managed care plans to assure all services mandated in the provider agreement, including home health and private duty nursing, are available to all members just as we make available in FFS. This is outlined in Appendix G, 1.	
What requirements exist pertaining to credentialing?	OAC 5160-26-05 -Managed health care programs: provider panel and subcontracting requirements. (C) Provider qualifications. (4) When credentialing or recredentialing providers in connection with policies, contracts and agreements providing basic health care services, the MCP must use the standardized credentialing form and process as prescribed by the Ohio department of insurance under sections 3963.05 and 3963.06 of the Revised Code. Upon ODM's request, the MCP must demonstrate to ODM the record keeping associated with maintaining this documentation. Appendix H, pg. 95 3. Provider Subcontracting b. The MCP shall credential/re-credential providers in accordance with OAC rule 5160-26-05. The MCP shall ensure the provider has met all applicable credentialing criteria before the provider can, be listed as a panel provider. At the direction of ODM, the MCP shall submit documentation verifying that all necessary contract documents have been appropriately completed.	Same for MyCare	
What requirements/responsibilities do the plans have in managing their third-party administrators?	Appendix C, pg. 54 58. Subcontractual Relationships and Delegation. If the MCP's responsibilities or services under this Agreement are delegated to any first tier, downstream, or related entity (collectively, the other entities are "FDR" and any such agreement with an FDR is the "FDR agreement" or "FDR arrangement"), the MCP shall ensure it has an arrangement with the FDR to perform administrative services as defined below on the MCP's behalf.... (This entire section provides the information on managing third-party administrators)	Same for MyCare	
What authority do the plans have to deviate from the fee-for-service rates listed in the OAC? Reimbursement rates are often offered below operating costs. As small providers, home health agencies have very little ability to negotiate for higher rates	MCPs are not required to reimburse the same rates as fee-for-service Medicaid. With providers contracting directly with each of the Plans, they are able to negotiate their own rates with each of the Plans.	Same for MyCare	
What data are the plans authorized to use to determine payment?	ODM does not set the data criteria the Plans use when determining rate with providers.	Same for MyCare	
What are the requirement/limitations on post-payment audits?	Ohio Revised Code 5164.57 Recovery of medicaid overpayments (A) (1)Except as provided in division (A)(2) of this section, the department of medicaid mayrecover a medicaid payment or portion of a payment made to a medicaid providerto which the provider is not entitled if the department notifies the providerof the overpayment during the five-year period immediately following the end ofthe state fiscal year in which the overpayment was made.	Same for MyCare	
What is the allowed timeperiod for recoupments?	Appendix C, pg. 42 36. Health Information System Requirements. b. Electronic Data Interchange (EDI), Claims Adjudication and Payment Processing Requirements. vi. The MCP is prohibited from recovering back or adjusting any payments beyond two years from the date of payment of the claim due to the MCP member's retroactive termination of coverage from the MCP, unless the MCP is directed to do so by CMS, ODM, or applicable state or federal law and regulation. However, this does not prohibit the MCP or ODM from initiating a recovery or adjustment more than two years after the payment of a claim in the event of fraud, abuse, or as otherwise provided by applicable state or federal law and regulation.	Same for MyCare	

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What obligations do the plans have to make a request for more documentation	Each of the Plans may have different prior authorization, pre-payment, and post payment review polices that differ from FFS. They may require different documentation for each type of review based on the criteria they use. If providers don't submit the required documentation, they can request additional information. Also, ODM requires each of the Plans to have an utilization management program per OAC 5160-26-03.1 Managed health care programs: primary care and utilization management. (B) An MCP must have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. A MCP must ensure decisions rendered through the UM program are based on medical necessity.	Same for MyCare	
To what extent are the plans allowed to impact direct patient care? Override medical necessity?	Ohio Administrative Code rule 5160-26-03 Managed health care programs: covered services A)Except as otherwise provided in thisrule, a managed care plan (MCP) must ensure members have access to all medically necessary services covered by Ohio medicaidunder the state plan. Specific coverage provisions for "MyCare Ohio" plans as defined in rule 5160-58-01 of the Administrative Code are described in Chapter 5160-58 of the Administrative Code. The MCP must ensure: (1)Services are sufficient in amount, duration, or scope to reasonably beexpected to achieve the purpose for which the services are furnished; (2)The amount, duration, or scope of arequired service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition; (3)Prior authorization is available for services on which an MCP has placed a preidentified limitation to ensure the limitation may be exceeded when medically necessary, unless the MCP'slimitation is also a limitation for fee-for-service medicaid coverage; (4)Coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of theAdministrative Code and practice guidelines specified in rule 5160-26-05.1 of the Administrative Code; and (5)If a member is unable to obtain medically necessary services offered by medicaid froma MCP panel provider, the MCP must adequately and timely cover the services out of panel, until the MCP is able to provide the services from a panel provider. (The Plans can decide which medical criteria they will use to determine medical necessity. Many of the Plans use Milliman or InterQual for making medical necessity determinations.)	Same for MyCare	
What penalties/consequences exist for denial decisions that conflict with the contract or rule?	ODM uses a variety of corrective actions or financial sanctions as defined and outlined in Appendix N - Compliance Assessment System. 2. Types of Sanctions/ Remedial Actions b. Financial Sanctions	Same for MyCare	
Inconsistent reporting methodologies for EVV between managed care plans.	The MCPs are required to implement EVV in a manner consistent with the fee for service implementation. If a plan is deviating from those requirements, please send specific details and examples to EVV@medicaid.ohio.gov.	Same for MyCare	