MITS BITS PROVIDER INFORMATION RELEASE

Transition to Managed Care on July 1, 2018

May 18, 2018

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In preparation for integrating community behavioral health center services into managed care, ODM wants to ensure providers have the information they need to effectively collaborate with managed care plans.

How Do I Learn in Which Plan a Medicaid Recipient is Enrolled?

The MITS provider portal can be used to check eligibility and plan enrollment. Providers can also submit an EDI 270 (Eligibility and Benefit Inquiry) to ODM with a list of Medicaid covered individuals. ODM's 271 response (Eligibility and Benefit Response) will identify in which plan each Medicaid recipient is enrolled. This same 270/271 process can then be addressed to each plan with their respective members to get information, including the plan's member ID.

Medicaid Eligibility and Managed Care Day One Enrollment

Previously, it took an average of 45 days for a Medicaid eligible individual to be enrolled in a managed care plan. Individuals were covered by traditional fee-for-service (FFS) Medicaid until enrollment occurred. Effective January 1, 2018, newly eligible individuals have been assigned to a plan effective on the first day of the month in which they are found Medicaid eligible. While enrollment data moves between the various systems as quickly as possible, information is shared through batch processes that may take several business days to execute. Managed care plan enrollment information is generally updated in MITS within 48 hours. Immediate MCP enrollment allows for faster access to care management and better access to services.

Who Receives Medicaid Through Fee For Service?

Approximately 90% of Medicaid recipients are enrolled in a managed care or MyCare Ohio plan. The eligibility and enrollment criteria are outlined in OAC rule 5160-26-02 http://codes.ohio.gov/oac/5160-26-02v1 and rule 5160-58-02 http://codes.ohio.gov/oac/5160-58-02v1. While most individuals are required to enroll in a plan, others may voluntarily enroll including individuals who have a developmental disability (DD) level of care and are enrolled in a DODD-administered HCBS waiver.

Some individuals excluded from managed care enrollment include:

- Individuals with a DD level of care who are residing in ICF–IID Facility;
- Individuals enrolled in PACE;
- Individuals residing in a nursing facility except those enrolled in MyCare Ohio;
- Individuals receiving HCBS waiver services except those enrolled in MyCare Ohio;
- Individuals who are dually eligible for both Medicaid and Medicare who do not reside in a MyCare Ohio Demonstration County.

All individuals with Group 8 (Expansion) eligibility are required to enroll in a plan even if they reside in a nursing facility or are on an ODM-administered HCBS waiver.

When Can Recipients Change Plans?

Managed Care

- **Between day 1 and day 90:** Individuals are enrolled in a managed care plan on day 1 and have 90 days to change plans from the first date of the month following enrollment.
- **Open Enrollment:** After initial enrollment, members may change plans during the open enrollment period in November of each year.

MyCare Ohio

- **Opt-In:** Individuals enrolled in a MyCare Ohio plan may change plans on a monthly basis.
- **Opt-Out:** If individuals are opt-out, they follow the managed care timeframes above.

Transition of Care for Community Behavioral Health Center Services

When integrating behavioral health into managed care, ODM has allowed for a 6 month transition of care. The managed care plan must allow a member to continue receiving services through out-of-network providers until December 31, 2018. This timeframe was extended to include an open enrollment period to allow members to easily change plans.

For continuity of care purposes, the managed care plan will make the following efforts:

- Work with the service provider to add the provider to their network; or
- Implement a single case agreement with the provider; or
- Assist the member in finding a provider currently in the MCP's network.

Managed Care Plan Resource Guide

Please click HERE to view a Resource Guide on behavioral health managed care integration that includes Ohio Managed Care Plan requirements, resources, and contact information.

IT Documents on Plan Requirements

Refer to http://bh.medicaid.ohio.gov/manuals under "Billing and IT Resources" for the following:

- To view the worksheet on how rates are determined for each code/practitioner combination, refer to "Supervisor Rendering Ordering Fields."
- To view the table that represents what additional licenses can be added to a practitioner's enrollment, refer to the "Dual Licensure Grid."
- To view the table that explains certain IT system differences amongst the Plans, refer to the "July 1 IT Specifications" spreadsheet.

ODM's Managed Care Complaint Form

Should any issues arise with an MCP, providers are encouraged to reach out directly to the plan first. If providers continue to experience challenges, providers may submit the Provider Complaint Form to ODM. The form can be found at http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx. Complaints filed using this form will be reviewed by ODM staff. ODM will follow-up with the plan as well as with the provider who filed the complaint.

Upcoming Managed Care Spring Forums

Please click HERE to view the previous May 2nd MITS Bits on *Upcoming BH Provider Forums*.

In addition, in response to the demand from BH providers, the plans, ODM, and OhioMHAS agreed to sponsor an additional provider forum in Central Ohio – please click HERE for registration details and more information.

To view the corresponding Provider Forum presentation, please click HERE.

Enrollment of Dependently Licensed Practitioners and Paraprofessionals

Please click HERE to view the April 25th MITS Bits on *Important Reminder and Updates: Enrollment of Dependently Licensed and BH Paraprofessional Practitioners in MITS.*

Prior Authorization

Please click HERE to view the May 16th MITS Bits *on Prior Authorization and Behavioral Health Integration.*