Requirements to Move Forward with Managed Care Carve-In on July 1, 2018 and Ensure Timely Payment for Continued Service Capacity and Patient Access

Ohio can successfully move forward with managed care integration on July 1, 2018 only with the following practices in place to ensure continued service access and capacity:

A. Effective July 1, 2018 to achieve timely payment, providers shall submit all current fee-for-service claims that will become the responsibility of managed care via MITS to the Ohio Department of Medicaid (ODM) for adjudication, and ODM shall transmit data to the managed care plans (MCPs) on claims adjudication. The MCPs shall be responsible for paying the claims to providers within 15 days of claims submission to MITS, the same timeline within which the state is currently paying. Providers shall receive remittance advice from MCPs and shall continue correcting and resubmitting denied claims to MITS for adjudication as they do now. This arrangement will remain in place until at least June 30, 2019.[1] *(See second page for rationale.)*

Requirement A shall be implemented in conjunction with the strategies already agreed upon by ODM with implementation details further articulated here:

B. All MCPs will make "Contingency Payment(s)" which shall be defined as required payments by ODM in the amount 54.6% of each provider's Medicaid revenue (inclusive of MyCare claims) in 2016 for up to four consecutive months beginning July 1, 2018. Contingency Payments shall be made on the first of the month for the upcoming month. For example, the Contingency Payment for July shall be made on July 1, 2018.
    a. The reconciliation period for Contingency Payments shall be July 1, 2018 to June 30, 2019. After July 1, 2019, the reconciliation process will occur to determine the net effect of overpayment and underpayment for each provider electing to accept the cash advance Contingency Payments. Each provider electing to accept the Contingency Payment and each MCP providing the Contingency Payment shall have 12 months (July 1, 2019 to June 30, 2020) to settle the reconciliation amount. ODM shall ensure that under no circumstances will funds be withheld from providers before the end of the reconciliation period of June 30, 2020 unless agreed upon by the MCP and provider.
    b. Providers will be permitted to accept Contingency Payments while also submitting claims and receiving payment through MITS to the MCPs.
C. ODM shall maintain all transition of care requirements with the MCPs and follow all fee-for-service standards for payment and prior authorization through June 30, 2019.
D. ODM and MCPs shall allow covered Ohioans to use any behavioral health provider until at least December 31, 2018 and shall be required to reimburse the behavioral health provider for providing service regardless of contract status between the MCP and the provider.
E. ODM shall form an implementation task force to monitor implementation of this plan, MyCare implementation, and claims testing between MCPs and providers. ODM should also be required to conduct an independent evaluation to assess the impact of Redesign on system capacity and the ability of Ohioans to access services.

[1] *This recommendation is based on Indiana's Medicaid managed care structure where claims are submitted by providers to the state for adjudication and then data is transmitted to plans for payment, care coordination, and utilization management. Indiana uses the same software vendor as Ohio, DXC, for the processing of Medicaid claims.*

Rationale and Benefits of *Recommendation A* for Moving Forward with Managed Care Carve-In on July 1, 2018 for the Clients and Families that Need Behavioral Health Services:

Recommendation A allows claims to be submitted by providers to MCPs through MITS and ensures the following benefits:

- ODM rolls forward with the carve-in, assigning responsibility for claims payment, care coordination, and utilization management to MCPs on July 1, 2018.
- MCPs receive responsibility for the covered lives as of July 1, including resources for payment of services, care coordination, and data for utilization management and cost analysis.
- Providers continue with claims data submission through MITS, the automated process with which they are experienced and have a higher likelihood of claims adjudicating for payment that supports weekly cash flow. Providers will contract with MCPs by 12/31/2018.
- ODM already processes behavioral health claims and already transmits data to plans on a daily basis.
- MyCare claims adjudication and payment remain with MCPs and become the test ground for IT fixes and overall ability of providers and plans to collaboratively achieve clean claims for services delivered and timely payment of claims.
- Augments legislature's and administration's oversight and accountability of increasing the allocation of public resources to CareSource while they are actively on a remediation plan. Creates transparency by allowing time for CareSource to work through identified internal issues that resulted in violation of timely payment standards for multiple quarters, including moving away from manual claims processing, training hundreds of newly hired staff, and rectifying aged accounts receivable with all providers.