Ohio Senate
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1 Capitol Square
Columbus, Ohio 43215
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Mark Romanchuk
State Senator
22nd Senate District

March 7, 2024

Director Maureen Corcoran
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

Dear Director Corcoran,

As we discussed, I am sending you the list of ongoing issues providers in our state are continuing to have with the Next Generation Ohio Medicaid. I ask that you and your team address these issues promptly and keep me informed of the status of the resolutions to these issues. Resolution status should be monthly and may include testifying at a future JMOC hearing.

Thank you.

Sincerely,

Mark Romanchuk
State Senator
22nd State Senate District

cc: Jada Brady

JMOC Meeting

2-15-2024

Alcohol, Drug Addiction and Mental Health (ADAMH):

Robert Peare, Database Developer for Fairfield County ADAMH Board, 740-475-1986, shared concerns on behalf of ADAMH centers and Trading partners. ADAMH serves lower income families and help with cost for those that don't qualify for Medicaid. It is imperative from a budgeting and auditing standpoint that ADAMH can determine who is Medicaid eligible and who isn't so they don't pay for services erroneously that can be covered by Medicaid. Since February 1, 2023, ADAMH have encountered multiple data issues. Below are noted concerns:

Recursive Search:

- Roughly 20% of resident eligibility searches are incorrect. If one data point within the search criteria does not match, ODM systems will not produce a valid response and often results in a false negative of being eligible. Several hours of administrative work are required to review each denial for accuracy.

False Duplicates (AAA 76 Errors):

- Search results show a resident having no eligibility for the entered timespan yet is showing resident as being returned as a duplicate client.
- ADAMH thinks the issue stems from the system using both the resident's Medicaid number as well as the Managed Care member number. Only Medicaid numbers should be considered in the search. Especially when recipients have the freedom to switch plans or in cases of a child being in the foster care system and then adopted.
- Additional contributing factor, the system seems to be searching for eligibly time frames longer than the 12-month search inquiry.

Recursive Search extended:

- Prior to February 1 of 2023, if a client was found in the recursive search we would receive the name, date of birth, SSN and Medicaid number **as they were recorded in the Medicaid system.** After February 1 of 2023, we are only getting back the exact information we submitted, in other words, we are not getting any information back from the ODM side of the equation with which we can update our systems.

Significant Decline in Claims to Ohio Mental Health and Addiction Services (OMHAS)

- Since the state adjudication system for ADAMH boards went away (MACSIS) ODM has been transmitting data to Ohio Mental Health and Addiction Services (OMHAS). That data is both member and claim information. In FY 2022, Fairfield County's ADAMH had 110,000 claims in that

data. In FY 2023, this dropped to 70,000 claims with a noticeable, steep decline after February 1, 2023, with the conversion. For FY 2024 year to date, Fairfield ADAMH have 6,800 claims in that same extract. ADAMH boards in general, want to know what is causing that drop off in claims transmitted to OMHAS. The significant drop interferes with their legislative requirements, which can't be done with a 90% drop in claim volume is an issue.

Ability to request a new Trading Partner Number:

- Receiving error message when following known instruction. ODM support desk informed him that the issuing of trading partner numbers had been suspended as of February 2023 and had not been reinstituted. If ODM is issuing new trading partner numbers where is the documentation for doing so?

Trading Partners File Processing Confirmation

- Confirmation that the file processing of *all* files is first in first out. They have evidence that this is not happening in our eligibility files. They want confirmation that processing of files is, in fact, first in, first out (FIFO). The evidence suggests a process that is not truly following this practice.

  Trading partners in the 21200 – 21500 range generally experiencing about a 1 – 2-hour response time for their 270/271 File response time. (270 is the eligibility inquiry, 271 is the eligibility response). Trading partners in the 21700-21799 range are generally experiencing response times of 4 – 6 hours. I have an extremely small data set (7 trading partners reported data to me).

  While this type of delay is not huge now, it was extremely noticeable in the early days of 'go live' where trading partners in the 21200 – 21500 range were having 1 day wait times and trading partners in the 21700 – 21799 range were sometimes waiting 2 weeks to get a response. * No action needed. Seeking clarification only.

Nonaccess to access to the PNM Module

- ADAMH boards **do not** have direct access to the PNM module in the Medicaid system, this means they do not have access to individual client lookups without the intervention of a provider (Substance Use and/or Behavioral Health) agency within our networks of care. Prior to February 1 of 2023, if a client was found in the recursive search they would receive the name, date of birth, SSN and Medicaid number **as they were recorded in the Medicaid system.** After February 1 of 2023, ADAMHs are only getting back the exact information submitted, in other words, they are not getting any information back from the ODM side of the equation with which we can update our systems.

  It is important to note, **both** sides of the client information systems (ODM and ADAMH billing systems) can be wrong, and ADAMH have no direct source to the information in the ODM system except through the 270/271 process. If a recursive search is re-implemented, they will want to get the data from ODM in that response file. This helps them navigate incorrect data much, much, much more efficiently. An individual client lookup may take 2 – 3 minutes per person, if they get the information in the 271 file there are reporting mechanisms in place to help identify discrepancies between what ADAMH have in their system and what ODM has in theirs. ADAMH can then refer the client to ODJFS if ODJFS has incorrect information and correct our information

if our local systems are incorrect. ADAMH reporting can identify the discrepancies of 1100 clients in about 30 seconds. The relief of this and other administrative burdens will make them more productive.

Ohio State Medical Association:

Todd Baker, Chief Executive Officer for the Ohio State Medical Association 614-527-6762.

Medicaid FFS System Issues

- OH, Medicaid FFS claim denying for generic reason of CO-AI; when Medicaid is contacted, the practices are told this is a known issue and are working on a fix – problem has now persisted for over a year with no timeline of resolution given to providers.
- OH, Medicaid FFS claims that are filed electronically can no longer be viewed, corrected, or have claim attachments uploaded via the MITS portal. Practices indicate there is no way to send supporting documents with a claim to OH Medicaid. No way of verifying claim status without contacting OH Medicaid directly via phone.
- Continued delays in payment of OH Medicaid FFS/Medicare crossover claims - up to 90 days after Medicare pays for an undisclosed reason.

ODM General System Challenges

- Challenges with credentialing information flowing from Medicaid to MCO. For example, in some cases practices are getting Medicaid managed Care plan rejections and denials for a provider that is not linked to the group when PNM portal shows that they are. Practices have been told it should be updated daily and many times the MCO did not have the same info. Sometimes enrollment and affiliation status's change randomly. At times a provider was ACTIVE one day and REMOVED the next. Additionally, sometimes specialty, CAQH, and NPI information came across incorrect for some providers.
- PDM Administrator –If a provider has more than one employer, only one group/organization can maintain the Provider profile. And any group/organization can submit a request to change the PDM administrator without the current organization or provider's knowledge.

MCO Issues Noted by Others

- Medicaid Manage Care Plans are not always following OH Medicaid guidelines when processing claims. One example, Anthem lab claims denying for invalid modifier requesting use of QW, Anthem services denied as not payable when performed by this type of provider, Anthem repeated concurrent care denials (practice does not have these denials for FFS Medicaid). Have not been able to resolve with Anthem.

Ohio Hospital Association

Quyen Weaver, Senior Director, Health Economics and Policy, of the Ohio Hospital Association, (614) 221-7614.

Inability to view electronic data interchange (EDI) claims on the Provider Network Management (PNM) portal

- The absence of this functionality in the PNM portal has been a pain point for OHA members. As a result of this system limitation, members have been unable to check claim status on claims submitted via the EDI on the PNM portal. This system limitation prevents providers from viewing claim status so they cannot tell whether that claim has been processed appropriately. This functionality is one that members constantly ask about, as it would help improve their revenue cycle workflows significantly. During our meeting, ODM shared this functionality will be implemented under Phase 3B, which is currently in their test environment. An ETA has not been announced.

Invalid provider affiliation rejections

- The new system requires the affiliation of each physician/practitioner to each specific site rather than at the group level. These rejections include "RENDERING NPI IS NOT LINKED TO YOUR BILLING PROVIDER NPI. YOU NEED TO CONTACT PROVIDER ENROLLMENT AT OHIO MEDICAID TO GET THESE NPI LINKED." and "Invalid affiliation between Rendering and Billing providers". It is extremely burdensome for our members to affiliate each physician/practitioner to each specific site rather than to a group. During the meeting, ODM and Gainwell indicated they would investigate the possibility of requiring affiliation at the group level rather than specific site level.

Eligibility-related issues

- There are discrepancies between ODM's eligibility data and the managed care plans' eligibility data which results in claim denials and additional administrative burden on members to determine the correct payer. These discrepancies also result in coordination of benefit (COB) takebacks conducted by the managed care plans. There is also a system defect that denies an entire presumptive eligibility claim instead of paying for the eligible days.

Timely filing denials due to ODM's systems issues

- Longstanding systems defects and issues have started to deny claims for timely filing since this edit is currently purely based on the claim's date of service/discharge. Our members continue to resubmit claims with dates of service/discharge from over a year ago and those claims are being denied for timely filing. We asked ODM to waive timely filing edits until their system is mostly defect-free. Additionally, we requested that ODM issue a policy statement, so all providers are aware of the department's policy and intent regarding timely filing edits on traditional and managed Medicaid claims. During the meeting, ODM indicated this announcement is forthcoming.

Critical error in the PNM portal

- Since go-live on Feb. 1, 2023, members have reported seeing a "critical error" message when using the PNM to work trouble claims, attach documents or manually submit claims. This error erases everything, such as a manually entered claim, so members must re-key the claim again. This error has been sporadic since go-live but has become more frequent over the past few months.

Additional noted concerns/requests that were stated by the Ohio Hospital Association in the meeting:

- Requesting more transparency
- Requesting timely reimbursement. Currently experiencing 8–12-month delay for reimbursement of service
- Receiving invalid Provider rejections, denials and under payments. They also believe there are missing claims, which prevents them from budgeting properly.
- Seen an increase in overall Medicaid Claims and delay in claims functionality/reimbursement is a hardship.
- More details on reports will relieve call volume.
- Believe ODM should do a better job of prioritizing issues and would like to know how they prioritize issues.

Richland County's Mental Health and Recovery Services Board (MHRSB):

Angie Parker, I.T. Director, MHRSB of Richland County, 419-774-1426

Their Board is unique in that they submit Medicaid billing files on behalf of a small SUD (substance use disorder) provider. The Community Alternative Center, CAC, is an accredited residential placement and treatment center for adult court offenders as part of a jail diversion, treatment programming and sentencing option for Common Pleas and Municipal Courts across the State of OH. CAC receives court referred offenders from about elven (11) counties in the state for jail diversion.

<u>Challenges under the OMES System:</u>

Inadequate Test Environment

- Not knowing for certain if a Testing site is available or monitored today as we ourselves are past that process now. However, new billing software systems come and go often. Testing is vital to ensure systems are communicating with one another. Since issuing new TP #'s has been halted

for over a year, there will be folks wanting to Test their systems with OMES. I respectfully request that Testing be available with timely response. Testing under the old system was a 24hr turnaround response.

Inadequate Eligibility 271 Response

- Difficulty in obtaining current, useful, Medicaid eligibility. Eligibility is paramount to paying providers correctly the first time for members. I will not speak to this as my colleague, Robert Peare, has evaluated this aspect extensively. Just know that the 270/271 eligibility challenges expressed in his synopsis are our challenges as well.

Response files for 837P billing files

- When submitting 837P billing files there is an order of operations, for lack of a better term. The order goes like this:
    - Billing entity submit 837P billing file (to OMES)
    - A 999 should be received next which is an acknowledgment the system (OMES) has Accepted, Partially Accepted or Rejected the file. We watch for these.
    - Next comes a 277 (from OMES) this is essentially a detail of the claim lines in the file and if they were accepted, or not.
    - Lastly, OMES, issues what is called an 835. This is an electronic payment file that we process in our billing system that states what was paid, denied, to whom, etc…

- Response files are purged in two weeks. This is a very narrow window of opportunity for smaller organizations to retrieve their response files. If one is on vacation and the backup person becomes sick, you're out of luck. Requesting a document be reissued to the portal is fruitless. Medicaid Fee For Service remittances can be pulled for years into the past (still today as well via the PNM). A happy medium to these two examples would be helpful.
- A plethora of 277 response files are issued against a single file. We have been unable to determine a reason for being issued multiple 277 responses for one file. Sometimes four or more. One complete response is sufficient. This was accomplished under the old system. What we find missing from the 277 are the claim lines *not* accepted for processing. What used to be a tool is useless when users are left to piece together multiple 277's and not obtain what happened to any denials. Additionally, at times the 277 is received *after* the 835 electronic payment file.
- Denial of services. I speculate there is a disconnect between file loop processes at OMES, to the MCE and back to OMES somewhere. Denials are rampant when this was not the case prior to the implementation of OMES.