OhioRISE | Resilience through Integrated Systems and Excellence

CME and Provider Training

Presenter name

aetna™

Date of presentation

Agenda

- Important Information for Implementation
- Aetna/OhioRISE Provider Experience Team
- Secure Portal – Availity
- Prior Authorization Process
- How to Submit a Claim
- Provider Disputes
- Contacts and Resources
- Child and Family Team and Care Plans

Important Information for Implementation

Ohio Medicaid's Next Generation Program – Staggered Implementation

ODM has adopted a phased implementation of Next Generation Ohio Medicaid program to ensure members and providers experience a smooth and seamless transition

- Our first priority is our members and the providers supporting their care
- Ensures members and providers experience a smooth and seamless transition
- Eligible members will continue to receive the full complement of Medicaid benefits available today
- Providers can continue serving the 3.34 million Ohioans covered by Medicaid, working with current MCOs and the OhioRISE Plan using processes and procedures practiced today

Description of Implementation Stages
Stage 1: On July 1, 2022 **OhioRISE** will begin providing specialized services, which will help children and youth with behavioral health needs and help those that receive care across multiple providers be more coordinated.
Stage 2: In October 2022, **Centralized Provider Credentialing** will begin through the Ohio Medicaid Enterprise System (OMES) Provider Network Management (PNM) module, which will reduce administrative burden on providers. Also, the **Single Pharmacy Benefit Manager (SPBM)** will begin providing pharmacy services across all managed care plans and members.
Stage 3: In the last few months of 2022, ODM will finish implementing the Next Generation program with all seven **Next Generation managed care plans** beginning to provide healthcare coverage. ODM will also complete the OMES implementation including the **Fiscal Intermediary (FI)** which will simplify and streamline the provider process for submitting claims and prior authorizations.

Initial OhioRISE Credentialing/Claims/PA Processes

Now through later in 2022:

Credential directly with Aetna/OhioRISE

Beginning July 1, 2021: submit claims for OhioRISE services and prior authorization requests directly to Aetna Better Health of Ohio

Later in 2022:

ODM's centralized credentialing and claims/prior authorization submission systems will be implemented later this year.

Be on the lookout for additional communications from ODM in the coming months regarding trainings for the:

- Provider Network Management module
- Centralized Credentialing
- Fiscal Intermediary
- Single Pharmacy Benefit Manager

OhioRISE Provider Enrollment

Eligible providers that wish to bill for Medicaid covered services need to enroll as an Ohio Medicaid provider **and obtain an active Medicaid ID number.**

OhioRISE rendering and billing providers need to enroll as an Ohio Medicaid provider and contract with Aetna for the services they provide

- https://portal.ohmits.com/Public/Providers/Enrollment

MRSS and CANS providers also need to contract with the Managed Care Organizations (MCOs)

Please contact Aetna by email at OHRise-Network@aetna.com to become a participating provider with OhioRISE

Please do not delay enrolling and requesting the addition of OhioRISE specialties so that you are ready to bill on July 1!

OhioRISE Specialties

Since March 9, several new provider specialties associated with the implementation of the OhioRISE program are available to you.

Please do not delay enrolling and requesting the addition of OhioRISE specialties so that you are ready to bill on July 1!

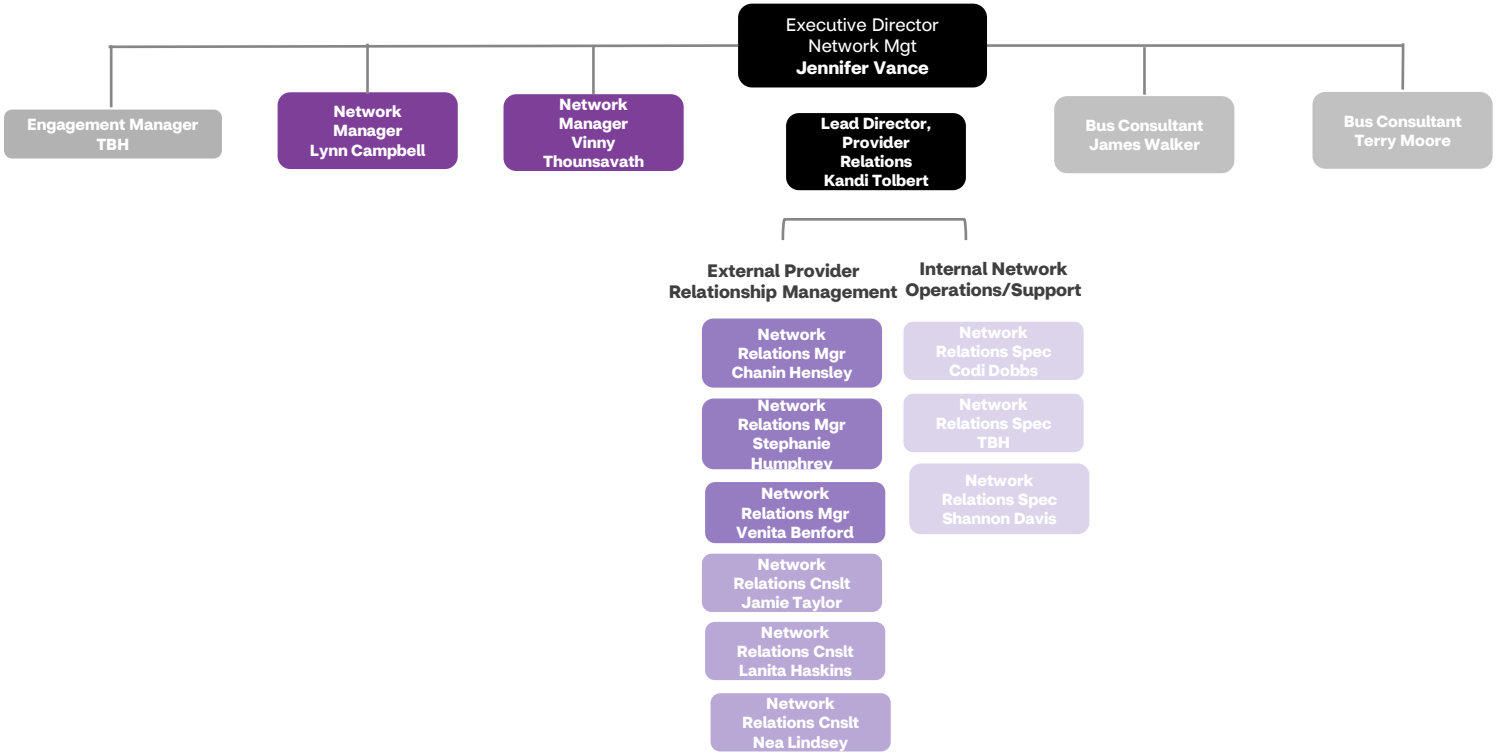
Which providers does this impact?

Providers of behavioral health services to children and youth up to age 21 who are interested in billing for the following new services:

- Child and Adolescent Needs and Strengths (CANS) Assessments
- Mobile Response and Stabilization Services (MRSS)
- Intensive Home-Based Treatment (IHBT), which includes IHBT, Multi-Systemic Therapy (MST), and Functional Family Therapy (FFT)
- Intensive and Moderate Care Coordination
- Behavioral Health Respite
- OhioRISE Waiver Transitional Services and Supports
- OhioRISE Waiver Out of Home Respite

Aetna/OhioRISE Provider Experience Team

OhioRISE Network Strategy and Provider Experience Team



OhioRISE Provider Experience Territories

Catchment Areas	Network Relations Reps
N, P, Q, R, S	Chanin Hensley HensleyC@Aetna.com
A, C, K, L	Stephanie Humphrey HumphreyS1@aetna.com
D, E, F, G	Venita Benford BenfordV@Aetna.com
H, I	Jamie Taylor TaylorJ13@Aetna.com
J, O, T	Lanita Haskins HaskinsL@Aetna.com
B, M	Nea Lindsey LindseyN@Aetna.com

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Aetna Better Health® of Ohio Secure Provider Portal

Aetna/OhioRISE Secure Provider Portal: Availity

Availity is Aetna's Secure Provider Portal used for prior authorization, claims status, electronic remittance advices, and added features with the health plan.

Many Ohio providers already have an account with Availity, and you will not have to do anything. You will see OhioRISE as an option when you click on the Aetna payer effective 7/1/2022.

If you DO NOT already have an account set up with Availity, each office will need an Administrator to begin the registration process. If you already have an account with Availity there's no need to set up a new account.

- The first step to create an account is to access www.Availity.com and click Register.
    1. Enter your Information
    2. Choose three security questions and answers
    3. Verify your information and create your account
    4. Confirm your email address within 24 hours
    5. Log in to Availity Portal
    6. Once this step is complete you will Register your Organization and Create accounts for other users

Getting Help and Training

The Availity Learning Center (ALC) has a large collection of recorded and live training opportunities.

To access the ALC, click Help & Training >Get Trained

Availity Help includes context-sensitive articles and field-level topics as well as Availity Portal release enhancement and updates.

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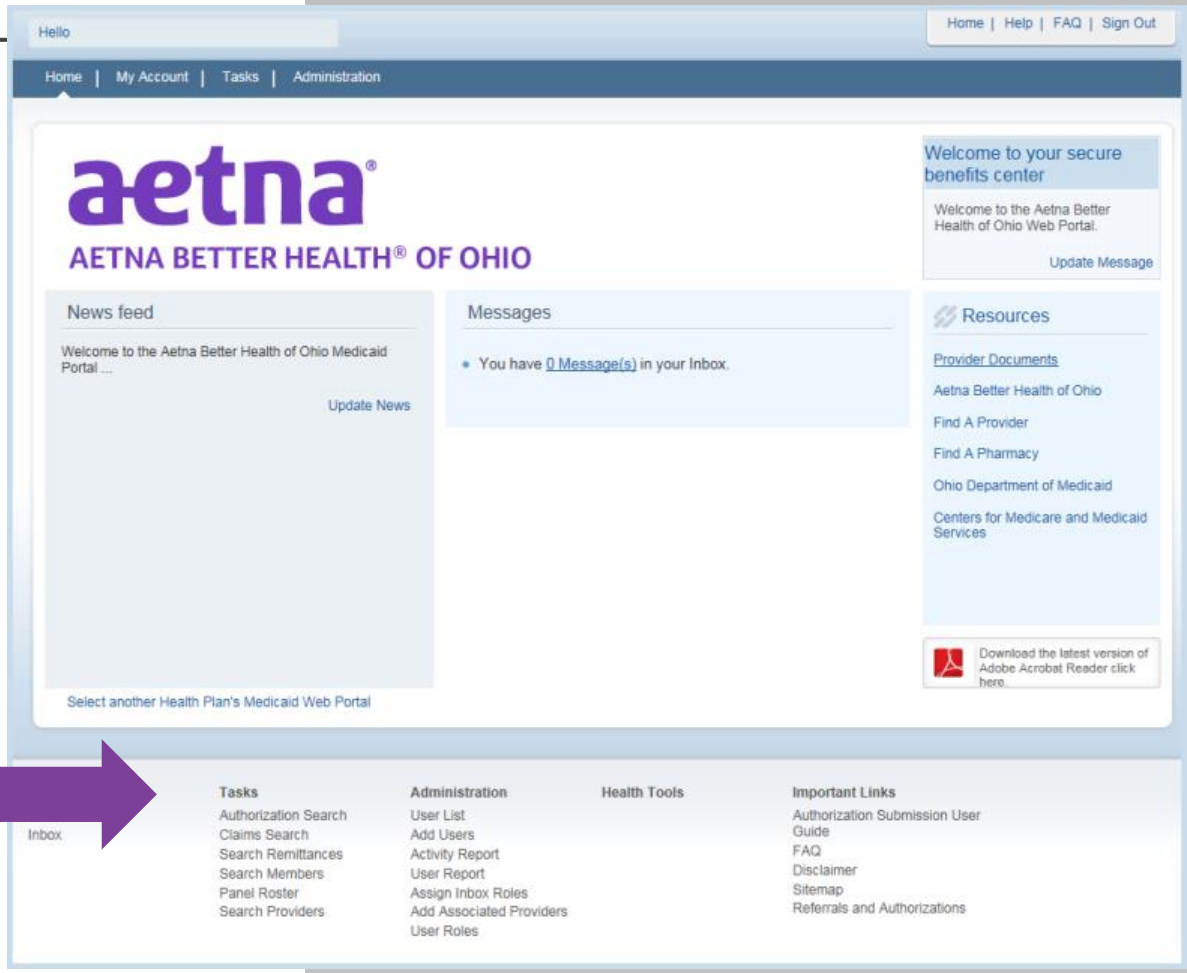
Secure Provider Portal

- This is an examples of our Secure Provider Portal.
- Contracted providers can sign up for this self service site online.
- Different levels of access can be assigned to designated staff using different roles.
- Under the “Tasks” menu, providers can review member eligibility, review and submit authorizations, review claims status & payment, and remittances.



Secure Provider Portal

The following information can be attained from the Secure Provider Portal:

- Enrollee Eligibility Search
- Provider List
- Claims Status Search
- Remittance Advice Search
- Provider Prior Authorization Look up Tool
- Submit Authorizations- types of authorization types are available:
  - Medical Inpatient
  - Outpatient
- Healthcare Effectiveness Data and Information Set (HEDIS®)

For additional information regarding the Secure Web Portal, please access the Secure Web Portal Navigation Guide located on our website or call our Provider Services Department at 1-833-711-0773 (option 2).

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Prior Authorization Requirements

Prior Authorization

Providers are responsible for complying with Aetna's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to be reported on their claims.

A list of services that require prior authorization will be available soon on our website at https://www.aetnabetterhealth.com/ohiorise/index.html

The Secure Provider Portal Authorization Tool gives providers the ability to:

- Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/ Healthcare Common Procedure Coding System (CPT/HCPCS) codes simultaneously
- Review Prior Authorization requirements by specific procedures or service groups
- Receive immediate details as to whether the codes are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
- Export CPT/HCPS code results and information to Excel
- Make certain staff works from the most up-to-date information on current prior authorization requirements

How to Request Prior Authorization

A prior authorization request may be submitted by:

- Submitting the request through the 24-hours-a-day, 7-days-aweek Secure Provider Web Portal located on our website https://www.aetnabetterhealth.com/ohiorise/index.html (only available to contracted providers)
- Calling us directly at 1-833-711-0773 (option 2)

Claims Submission

Aetna/OhioRISE – How to file a claim

To best ensure timely and accurate payment of your claim, submit a "clean claim".

A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service from a third party.

Clean claims are processed according to the following timeframes:

- 90% of clean EDI claims adjudicated within **30 days** of receipt

Timely Filing of Claim Submissions

- In accordance with contractual obligations, claims for services provided to an enrollee must be received in a timely manner. Our timely filing limitations are as follows:
  - *New Claim Submissions* –Please consult your contract for your contractual timely filing limit for new claims.
  - *Claim Disputes & Resubmissions* – Please consult your contract for your contractual timely filing limit for disputes and corrected claims.

- Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial

Aetna/OhioRISE – How to file a claim

Claim Submission Methods:

1. **Electronic Claims thru Provider's Own Clearinghouse.**
   - Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare or Office Ally, using 837 file format.
   - Please use **Payer ID 45221** when submitting electronic claims.

2. **Electronic Claims thru Provider Portal (Emdeon/Change Healthcare)**
   - Aetna Better Health of Ohio encourages participating providers to electronically submit claims through our portal at www.aetnabetterhealth.com/ohio ,
   - Select 'For Providers', then ''Claims' tab, "How to File a Claim", then link to 'WebConnect' on the page.

Aetna/OhioRISE

- Access the custom URL assigned to Aetna Better Health of Ohio: https://physician.connectcenter.changehealthcare.com/#/site/home?vendor=214555
- Create your ConnectCenter user account
- Create a submitter account through which you and your co-workers can share information in ConnectCenter.
- Create a provider record for use in claims and status inquiries

*__NOTE:__ Please DO NOT use Sign-Up more than once. Additional users and additional providers should be added after your initial use of Sign-Up and after you log-in to Connect Center.

Testing Your Connection

Change Healthcare as a clearinghouse vendor tests all direct connections with their payor partners, practice management vendors, other vendor partners and provider submitters.

- Many providers send claims through a vendor system that has already been tested with Change Healthcare.

Change Healthcare – ConnectCenter: Claims

ConnectCenter leverages the Change Healthcare clearinghouse for processing claims submissions. It provides detailed error information to expedite correction, claims tracking that indicates where in the adjudication process the claim is in and detailed claim reports.

Claims are either keyed into ConnectCenter using the 1500 and UB-04 claim forms or submitted into the system by using the claims upload functionality.

Manually Keying Entry

Providers who want to access ConnectCenter's claims direct data entry functionality should select:

- Claims
- Create a Claim from the main menu.

Submitting a Standard 837

Those who want to submit a standard 837 claim created in a practice management system should:

- Select Mailbox from the main menu
- Browse for the claim file
- Choose Submit
  - The claim file will be submitted to the clearinghouse for processing.
  - File must be in ANSI 837 5010 EDI format.

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Aetna Better Health® of Ohio Claim Tips

1. Claim numbers are assigned using the year and then the Julian date.
    - For example, 17001 at the beginning of a claim would indicate that claim was received on the First day of 2017.
    - A claim beginning with 16365 would indicate that claim was received on the last day of 2016.

2. Claim Indicators:
    - A claim with an “S” indicates it’s the secondary processing (Medicaid) but only if we also processed the Medicare claim within ABHO.
    - “A” indicates an adjusted claim, while “R” indicates a reversal.
        - Example: 17001E999999A1.

Help Desk Slide

ChangeHealth – Connect Center Portal Assistance **1-800-527-8133**

OfficeAlly Support – payersupport@officeally.com

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Participating Provider Disputes

Dispute Process

As a contracted provider, if you disagree with a claim decision Aetna has made:

- **Use the Secure Web Portal** to dispute the claim electronically after locating the claims on the right https://apps.availity.com/availity/Demos/Registration/index.htm

Provider Claim Disputes

- **Providers can file claim dispute no later than 12 months** from the date of service***, or***
- **60 calendar days after the payment, denial, or partial denial** of a timely claim submission whichever is later

NOTE: *Aetna will acknowledge receipt of dispute within five business days*

- Aetna will **resolve and provide written notice** to the provider of the disposition **within 15 business days of receipt**

NOTE: *If additional time to resolve a dispute is needed past the 15 business days, Aetna will provide a status update to the provider every five business days*

- Aetna will reprocess and pay disputed claims, when the resolution determines they were paid/denied incorrectly, **within 30 calendar days of the resolution** unless a system fix is needed then additional time is allotted

NOTE*: Aetna will automatically apply the corrective action or claims resolution to correctly adjudicate all other provider claims affected by the same issue*

Claims Payment Systemic Errors (CPSE)

Claims that were adjudicated incorrectly (overpayment, underpayment, denied) due to a systemic issue and it affected more than 5 providers will be documented and tracked for resolution.

A report outlining CPSE(s) will be posted on Aetna's website and updated monthly. The report will explain the following:

- A detailed description and scope of all active CPSEs
- The date the CPSE was first identified
- The type of all providers impacted
- The timeline for fixing CPSE
- The date(s) or date span(s) of corrected claims adjustment
- Status of CPSE issue
- Number of claims impacted

In addition communication will occur promptly to Ohio Department of Medicaid (ODM).

Aetna Better Health® of Ohio Contacts and Resources

Aetna Better Health® of Ohio Contacts and Resources

Providers can best utilize their contacts and resources by:

- Knowing your member's Care Manager and Care Management Entity (CME) to help collaborate care.
- Knowing your Provider Relations Liaison for ongoing support, claims projects, and provider updates. (if you do not know your provider liaison, please see slide 10)
- Utilize the network management mailbox for contracting requests OHRise-Network@Aetna.com
- Accessing the Aetna Better Health OhioRISE web-page for provider News & Notices and additional resources https://www.aetnabetterhealth.com/ohiorise/index.html

Provider Services Contact Information

More Information / Questions

Aetna Better Health of Ohio

1-833-711-0773

Child and Family Team and Care Plan (CFCP)

OhioRISE Delivery System: Roles and Responsibilities

OhioRISE Plan (Aetna)

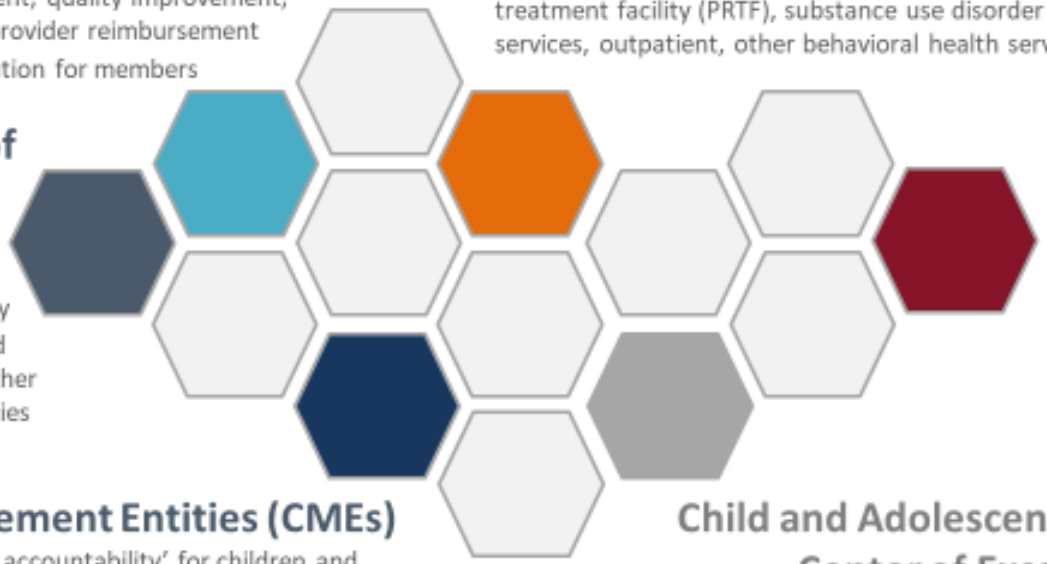
- Contract with CMEs and service providers to offer full continuum of behavioral health care
- Provide utilization management, quality improvement, network development, and provider reimbursement
- Provide limited care coordination for members

Service Providers

- Provide mobile response and stabilization services (MRSS), intensive home-base treatment (IHBT), inpatient behavioral health services, psychiatric residential treatment facility (PRTF), substance use disorder (SUD) services, psychiatry services, outpatient, other behavioral health services and DODD waiver services

Ohio Department of Medicaid (ODM)

- Provide oversight and coordination for quality monitoring and accountability
- Oversee Aetna using a shared governance structure with other Ohio departments and agencies



Managed Care Organizations (MCOs)

- Provide all non-behavioral health care to youth (e.g., physical health, dental)
- Assist with referrals, transitions of care, and care coordination

Care Management Entities (CMEs)

- Serve as 'locus of accountability' for children and youth with complex challenges and their families
- Offers two tiers of care coordination: intensive care coordination and moderate care coordination
- Build a system of care (SOC)

Child and Adolescent Behavioral Health Center of Excellence (COE)

- Support for implementing OhioRISE services through training
- Ongoing coaching, learning communities, and fidelity monitoring

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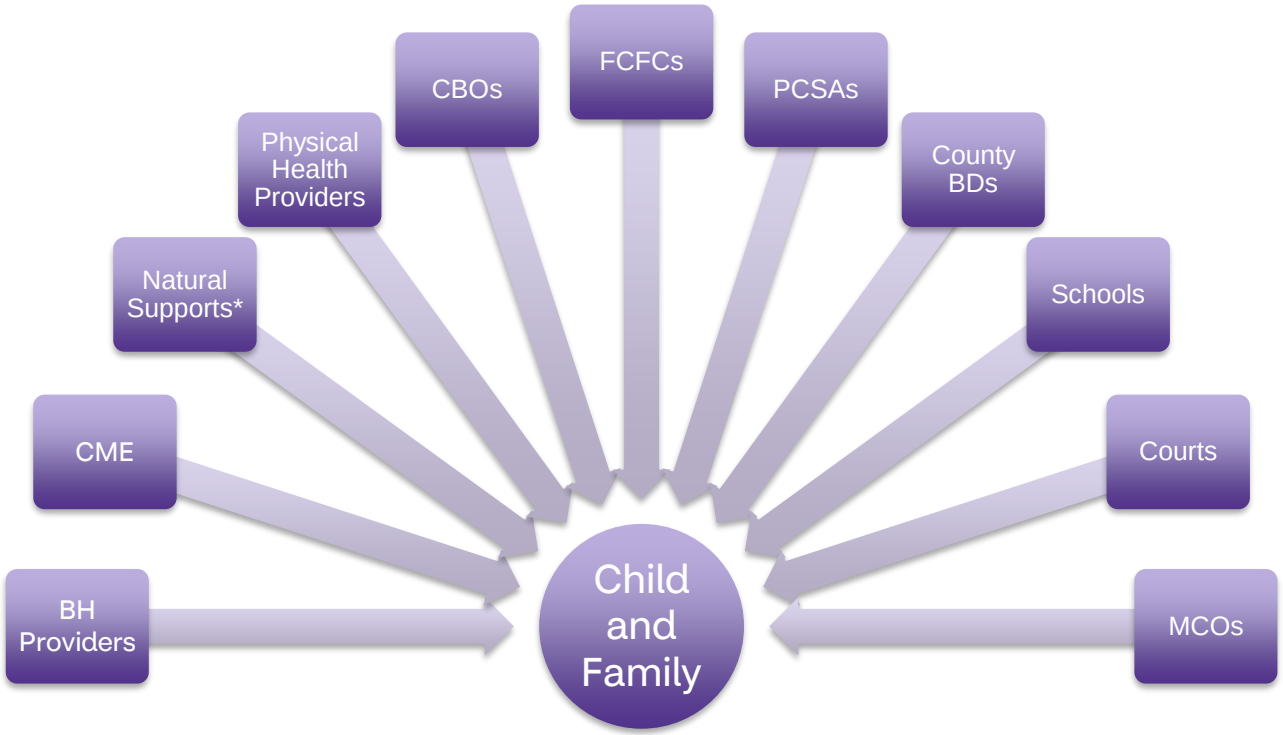
Child and Family Teams and Care Planning



Family Voice and Choice in Care Planning

- Elicit and Prioritize
- Focus on youth and family's perspective
- Reinforce member autonomy
- Center family values and preferences
- Use their words and avoiding jargon
- Enhance outcomes

CFCP Requirements

Completed for all members enrolled in OhioRISE

Must be developed within 30 calendar days from enrollment date

Care Coordinator must submit within 1 business day of completion

Minimal Requirement for Updating:

- Every 30 Days- Tier 3 (Intensive Care Coordination)
- Every 60 Days- Tier 2 (Moderate Care Coordination)
- Every 90 Days- Tier 1 (Limited Care Coordination)
- Or any time there is a significant change

Must be signed by member and/or guardian and Care Coordinator

Prior Approval and Prior Authorization

Two Processes – Prior Approval and Prior Authorization

A service that requires prior approval uses the child and family care plan (CFCP) process

- Service must be documented in detail on the child and family-centered care plan (CFCP), and the CFCP must be approved by the OhioRISE plan prior to the child/youth receiving the service and the provider billing for the service.
- Care coordinators will understand services requiring prior approval, work to ensure these services are considered by the child and family team (CFT), and when appropriate work to include providers of these services in the CFT .
- After developing CFCP with CFT, care coordinator submits the CFCP to the OhioRISE plan.
  - **For services that require prior approval before they can be provided/reimbursed, the OhioRISE plan must concur with the CFCP – this concurrence serves an approval to provide and bill for the services that must be approved using the CFCP process.**
  - The OhioRISE plan may concur with the CFCP, or they may request more information and/or follow-up discussion(s) with the care coordinator to improve the quality of the CFCP prior to issuing a concurrence.
  - If CFCP questions remain, the OhioRISE plan may issue a notice of non-concurrence, and the care coordinator will need to amend the CFCP and resubmit.
- Once a CFCP including these services is reviewed and concurrence (approval) is issued by the OhioRISE plan, the services may be used by the member and billed by the provider.

A service that requires prior authorization uses the provider-initiated prior authorization request process

- Providers of these services must request and receive authorization from the OhioRISE plan prior to billing for the service.
- Process follows the traditional provider-initiated prior authorization request pathway.
- Care coordinators will understand services requiring prior authorization, work to ensure these services are considered by the CFT, and when appropriate work to include providers of these services in the CFT and include these services on the CFCP.

For services subject to both processes, if the OhioRISE plan denies, reduces, terminates or suspends an approval or authorization for the service, this constitutes an adverse benefit determination that can be appealed in accordance with rule 5160-26-08.4 of the Ohio Administrative Code.

Prior Authorization

Prior Authorizations are provider initiated and follow traditional utilization management process for the following services

- Inpatient Treatment
- PRTF (available January 2023)
- ECT
- SUD Partial Hospitalization

These services have an initial benefit allowance and require prior authorization after allowance is exhausted:

- Intensive Home-Based Treatment and ACT (Greater than 180 days)
- Behavioral Health Respite (Greater than 50 days)
- MRSS (More than six weeks from completion of mobile response)

Note: Inpatient hospitalization may not be listed on the care plan due to emergent need.

Prior Approval

Request for 1915(c) waiver services to address the identified member's needs may include:

- Primary and Secondary Flex Funds
- Transition Services and Support (TSS)
- Out-of-Home Respite

Primary Flex Funds are available to all OhioRISE members

All flex funds and waiver services must be reviewed and approved on the care plan prior to providing services

Care Coordinator is responsible to verify member has remaining waiver funds prior to submitting a request for approval

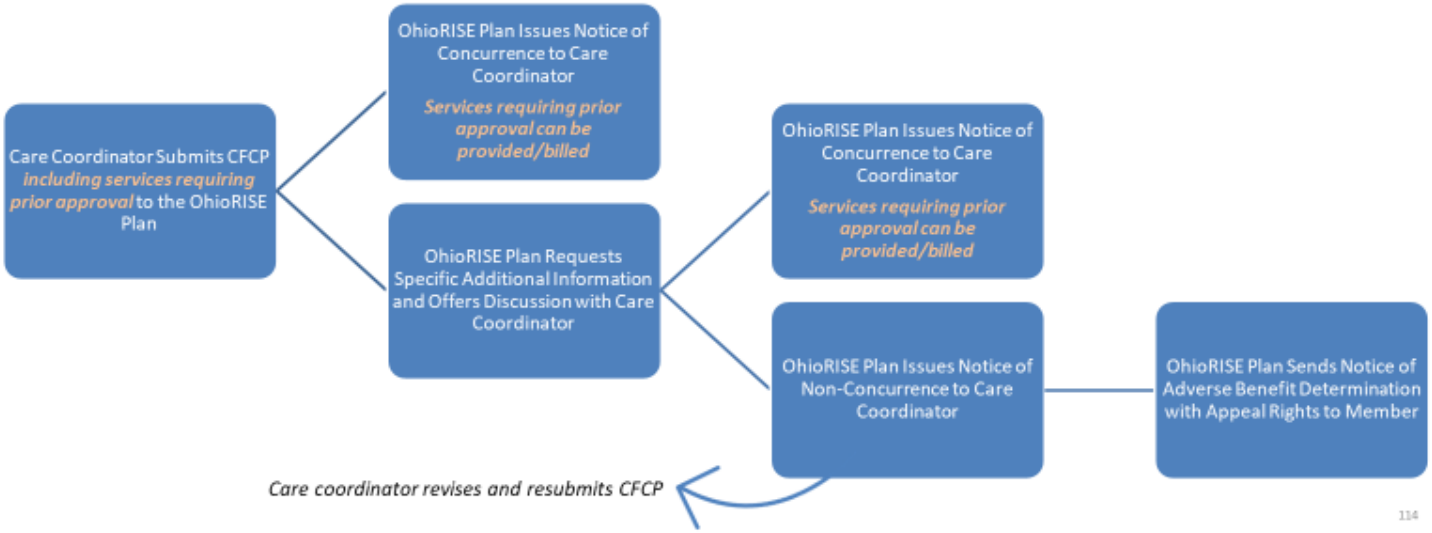
Waiver providers identified on the plan must

- Be an enrolled Medicaid provider
- Sign the CFCP
- Be provided a signed copy of CFCP

Prior Approval Decision Tree

Child and Family Care Plan (CFCP) Review Process when CFCP Includes Services Requiring Prior Approval

This entire process must take no more than five business days



Contact Information

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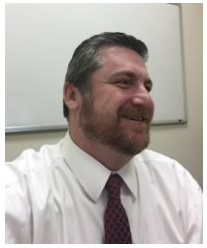

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