

MITS/MACSYS Focus Group Report-Out
Webinar Minutes
March 7, 2012

Welcome & Introductions

Director Tracy Plouck introduced the webinar. She stated that Doug Day and Angie Bergefurd will provide a report out today on the MITS/MACSYS focus groups that met over the past week. ODMH and ODADAS leadership look forward to feedback on today's session. They hope to engage with constituents in the most efficient way possible. The timeline is very short between now and July 1, 2012 and the transition to MITS is a very serious priority for the departments. The goal is to work effectively with ODJFS to ensure that payments are timely. Angie also thanked the group for participating today and during the previous focus group meetings. Next Angie and Doug presented the Power Point distributed during the meeting and via email, which is also posted on the ODMH website:

<http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/macsis/macsis-mits-claims-processing.shtml>

Go-Live Reality

Doug began by explaining that the state is working with a very tight time frame. They have a total of 116 days to implement the transition.

New Website

Angie stated that all of the information regarding the MITS/MACSYS focus groups is now available on a new ODMH web page (link above). This page contains all memoranda related to MACSYS and MITS claims processing in SFY 2013, as well as all group meeting agendas, handouts and minutes, including today's Power Point presentation. She added that comparisons of MITS and MACSYS companion guides can be accessed using the links found on slides 5 and 6 of the Power Point. Also included in these slides is information about ODJFS trading partner agreements, third party liability, and Medicaid spend down.

New Client Enrollment Focus Group

Doug provided the report out on the New Client Enrollment Focus Group. He stated that there are two enrollment scenarios, one with effective dates prior to July 1, 2012 and one with effective dates on July 1, 2012 or after. In the first scenario there will be no change for either Medicaid or non-Medicaid clients. On July 1, 2012 and after, providers and boards will not be required to enroll Medicaid clients, unless the board is paying for non-Medicaid services.

Question: How are out of county enrollments to be handled/what constitutes residency?

Answer: Angie replied that state staff has discussed the role of the MACSYS Support Desk after July 1, 2012. Typically, if there is no resolution within a quick time frame, the Support Desk assigns the number. However, after July 1, 2012, the department will no longer enroll Medicaid clients through MACSYS.

Question: Will UCI numbers then be obsolete?

Answer: Angie stated that the MMIS number (generated by ODJFS) will be used instead. The UCI number will only be needed when billing through MACSYS for dates of service prior to July 1, 2012.

Question: After July 1, 2012, do Medicaid clients need to be entered into both MITS and MACSYS, or just MITS?

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Answer: Doug stated that these clients will already be enrolled in MACSYS prior to July 1, 2012; after that point, this would depend on the arrangement. Some Medicaid clients could still be enrolled in MACSYS as part of certain payment arrangements.

Question: What if a client loses Medicaid eligibility? Could this client then be enrolled as a non-Medicaid client in MACSYS?

Answer: Angie said yes, the client could be enrolled as non-Medicaid if eligibility for Medicaid is lost. Technical details about this process are provided in the Power Point.

Question: Since the MACSYS Support Desk will no longer be available after July 1, 2012, can clients still be enrolled on July 1, 2012?

Answer: Angie clarified that the Support Desk will still be available and that clients can be enrolled on July 1, 2012.

Question: Will a MITS Support Desk that is equivalent to the MACSYS Support Desk become available on July 1, 2012?

Answer: Doug stated that ODJFS has a customer service arrangement in place. Contact information for customer service will be made available prior to July 1, 2012.

Comment: My concern with the current customer service arrangement at ODJFS is that it is very difficult to get assistance. You often get caught in a loop and seldom reach a live person. They do not respond to e-mail either.

Response: Angie stated that the departments will continue to work together to ensure that questions are answered in a timely manner.

Doug explained that one of the paradigm shifts of this transition is that there will be much more focus on coordination of benefits. The state is implementing a MACSYS benefit rule which will deny payment of Medicaid services provided to Medicaid clients after July 1. A new MACSYS denial code will also be used; this reason code will be mapped to a HIPAA remark code. He added that claims will be denied on the MACSS 835 and providers will need to bill those services to MITS.

Doug also stated that the nightly eligibility update process will continue in order to maintain Medicaid eligibility synchronization and to avoid duplicate Medicaid/non-Medicaid payments in the two systems. Only clients enrolled in MACSYS will be updated during the nightly eligibility update process. Medicaid claims with dates of service prior to July 1, 2012 will process as usual until the full phase out of MACSYS Medicaid is complete.

Question: Will MITS “pre-scrub” denials?

Answer: Angie stated that she is not sure, but does not think that the system will do this. Mary Haller added that when claims are entered into the MITS web portal, they are immediately accepted or denied. When they are submitted electronically, the information comes back on the 835 with the denial code, if applicable. In both cases, an explanation is provided if the claim is denied.

Retroactive Medicaid Eligibility & Medicaid Spend Down Focus Group

Angie reported that the state will continue to provide the same 3 files as in the past. If the claim

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was originally paid as non-Medicaid, it is reversed, the member's eligibility is updated, and the claim is split and adjudicated as a Medicaid claim. If the claim is denied as out of county, the member's eligibility is updated and the claim is split and adjudicated as Medicaid. In the event that the claim is un-finalized, it will be re-adjudicated. The non-Medicaid payback and Medicaid payment occur in the same payment cycle and appear on the same 835. For dates of service prior to July 1, the current process will continue; the new process will begin on July 1.

Angie also described adjustment codes which will be used beginning July 1. An identified HIPAA adjustment code (141) and adjustment group of CR will appear on the 835 that is associated with the MACSYS adjustment reason code of ADMBR. The provider will need to re-submit these claims either through the EDI or manual process. It is very important that eligibility is synchronized between MITS and MACSYS.

Boards are not required to split the claim after July 1; they could continue to use this function for informational or customer service purposes, but they will not be required to do so. The non-Medicaid reimbursement will be taken back from the provider. For retroactive Medicaid claims that are un-finalized, the member's eligibility is refreshed at the claim header and the claim is re-adjudicated at the detail.

The nightly Medicaid eligibility updates will continue in MACSYS after July 1. Only clients enrolled in MACSYS will be updated. Angie reported that the state has received many questions about boards providing information so that Medicaid consumers can be entered into the system. Providers can check eligibility through EDI or EVS vendors, manually through the web portal, or by phone using the IVR. Boards can continue to use MACSYS EEI to check eligibility during enrollment. She added that in the focus groups, there were many questions about Medicaid spend down. Medicaid eligibility and spend down reporting will not change at the local level.

Comment: What happens currently is that we have to communicate with the client's caseworker on services that will apply to a spend down. We have no way of knowing if other agencies/providers are doing the same for the same client. Being able to do this through ODJFS would make this process less manual and more accurate.

Question: Please define "un-finalized" and can these claims be seen in MITS?

Answer: Doug stated that "un-finalized" is a MACSYS term for claims that have not run through the full cycle. This means that the claim can still be edited. The same terminology is not used in MITS because it pays or denies claims immediately.

Question: Could ODJFS accommodate spend down by allowing providers to bill for all services, simply allowing the non-Medicaid claims to deny?

Answer: State staff will follow up on this question; however, Doug stated that it is recommended that providers use the front end approach, either through EDI or manually.

Question: Will there be a charge for agencies using 270 or 271?

Answer: Mary stated that there will be no charge for agencies; however, they may be charged by their vendors. She added that 270 and 271 can be processed directly in MITS. Agencies must follow the steps to become a trading partner with ODJFS first, but there are other options, such as

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hiring a vendor, that would incur additional costs.

Doug stated that to the extent that non-Medicaid services in MACSYS are also reported to the CDJFS, they may be counted toward the consumer's spend down amount. Until a consumer has met his/her spend down amount, services should be billed through MACSYS if the board is responsible for paying for them.

Question: Are non-Medicaid services forwarded automatically to ODJFS and counted against the spenddown?

Answer: Doug said no, these services are not reported automatically to ODJFS to be counted toward spend down.

Comment: What happens currently is that providers must communicate with the client's caseworker on services that will apply to spend down. We have no way of knowing if other agencies/providers are doing the same for the same client. Being able to do this through ODJFS would make the process less manual and more accurate.

Response: Angie stated that at this time, the local level processes should continue.

Medicaid Claims Run Out Focus Group

Angie described four scenarios proposed by the Medicaid Claims Run Out Focus Group. They are listed in the Power Point in no particular order and are not mutually exclusive. She explained that the scenarios address more efficient ways to handle the declining volume of claims that will be processed as the year closes out. These scenarios are:

- Individual boards negotiate to establish efficiencies, pooling resources in the process.
- Individual boards continue to operate under the status quo.
- Individual boards decide to cease performing claims and payment processing.
- Claims payment transfers to MITS at an agreed upon point, regardless of date of service.

Next steps for this group will include ODMH and ODADAS working with boards and Board Association staff based on individual board circumstances. ODMH and ODADAS will provide guidance related to negative amounts on 835s, provider paybacks, continued use of mCPE, and board financial reporting.

Question: In regard to run out, will the state work to accommodate individual local decisions?

Answer: Angie said yes, the state is willing to accommodate reasonable local decisions about handling claims run out.

Board Access to Data Focus Group

Doug stated that the authorization extract has not been distributed yet but will be finalized soon. There are no changes to the extracts, with the exception of the claims extract. Since MITS claims do not run directly through MACSYS, they will not come out of MACSYS extracts. ODMH and ODADAS will receive a claims extract file from MITS according to HP and ODJFS. They have agreed to put in filler data, and the state is currently discussing how that information will be subset and disseminated to the boards.

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Doug also explained that there will be no changes to the MACSYS claim extract for July 1, with the exception that Medicaid claims will decrease given that the extract will only contain dates of service prior to July 1. He added that the state is still working on combining MACSYS and MITS data. The RA/RJ, ERA will be discontinued on July 1, per the state's previous decision. Manually reversed Medicaid claim reports will stay in production until MACSYS completes Medicaid operations.

Question/Comment: Is it correct that current reports will remain the same, but boards will no longer receive the RA/RJ/ERA? I do not know if we have a system in place to replace this one. Will training be provided?

Answer/Response: Doug stated that this has been planned for quite some time; the state originally intended to stop disseminating the RA/RJ/ERA in January, but granted a six month extension to boards. Boards can still generate similar reports; they still have access to the data and could opt to create a report showing the same information. Providers will not have access to it other than the 835 payment file. This is the nationally required payment standard; this is why we are phasing out the other reports. Angie added that training will be provided for this.

Question: Will the RA/RJ/ERA continue for payments for service date or calendar date? When these reports are discontinued, how will we receive payment information?

Answer: Payments will be for service date. Doug stated that the HIPAA required payment format is the 835; this will be generated from MACSYS and will be the only payment file that boards and providers will receive.

Question: Will boards and providers continue to receive critical error reports, or will these claims be processed and denied through MITS?

Answer: Doug replied that these reports come from the Diamond system to identify claims that are structurally unsound to the point that they cannot be processed. MITS would not return these claims; it will deny them. For this reason, these claims will not appear on a critical error report, but as a denied claim with a denial reason code.

Doug stated that fields that do not map are described in slide 21 of the Power Point. Mary stated that these are related to privacy and confidentiality issues. Since the boards are in a business relationship with ODMH and ODADAS but not ODJFS, ODJFS is delegating the responsibility for maintaining privacy and confidentiality to ODMH and ODADAS. She added that the state has discussed the consumer data sets to which boards should have access; the only data to which boards have a legitimate claim is the data for services they fund, according to privacy laws. The concept proposed is the first cut at how the files should be configured.

Question: What is the state's level of commitment to providing data to boards?

Answer: Mary replied that the state is committed to providing data to boards on services they fund. Under HIPAA privacy and confidentiality, the state cannot provide the data unless boards pursue trading partner relationships with ODJFS.

Comment: Since boards are statutorily required to ensure health care for their consumers, it is very important for them to have access to this information.

Response: Angie stated that ongoing conversations will be needed; Mary is highlighting the fact

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that this includes a need for legal discussions.

Doug pointed out that this is an example of an area in which relationships could change; for example since ODMH and ODADAS will be receiving this data, they might be able to run reports for boards instead of directly providing the information. Hugh stated that provider representatives should also be part of this discussion; Angie agreed. It was agreed that a broader discussion about the need for boards to continue to receive information on behavioral health services they do not fund will be necessary.

Question: Based upon the concept discussed today, providers should not enroll Medicaid clients with the local board until they are no longer eligible for Medicaid, correct?

Answer: Doug stated that this was discussed in the focus groups. Medicaid clients receiving both Medicaid and non-Medicaid services will need to be enrolled to ensure that providers are paid.

Question: For consideration, couldn't eligibility denials for electronic claims in MITS be reported immediately/pre-edited to speed up cash flow?

Answer: Doug stated that manually entered claims will show denials immediately. Eligibility can also be checked prior to submitting the claim and EDI claims will appear on the 835.

Doug stated that three options were proposed for consideration in the Board Access to Data Focus Group:

- One cumulative MACSYS/MITS claim file
- A cumulative MACSYS file and a cumulative MITS file
- A cumulative MACSYS file and a weekly MITS file

Software Requirements for 837P/835 and EDI Standards for TPL Focus Group

The internal MACSYS and MITS 837P/835 transaction sets are not identical or interchangeable in terms of data content. Currently available information regarding the identified differences in the sets was distributed in the focus group and is also available on the website mentioned previously.

Doug provided an overview of the ODJFS trading partner agreement process, which is outlined in slide 26 of the Power Point presentation. It was noted that single trading partner agreements can be used for mental health and AoD providers, as well as other Medicaid lines of business. Providers must contact ODJFS to begin the process – paperwork requires a minimum of 2 weeks for processing. The trading partner ID is needed before MITS testing can begin. Doug emphasized the importance of understanding that the trading partner ID and ODJFS provider number are two different numbers.

ODJFS certifies partners based on transaction sets. The state recommends sequence testing, which arranges data in order of importance with the 837P/835 first. ODJFS is making an upgrade to the test environment at the end of March, so testing will be postponed at that point until April 7, 2012. Until business requirements are worked through with ODJFS and HP, testing cannot be conducted.

Question: Has the state heard concerns from vendors related to the compressed time frame for

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testing? It is less than 3 months.

Answer: Mary stated that she has not heard any concerns about this. Angie stated that ODMH and ODADAS plan to have a separate, more detailed conversation with vendors about testing issues.

Batch Medicaid Eligibility Verification Options

ODJFS trading partners will be able to use the 270/271 transaction set for batch eligibility verification. As mentioned previously, providers can check individual eligibility via the MITS web portal or the IVR phone option; vendors can be used to check eligibility as well.

Pharmacy Approach – Mental Health Medications

Angie stated that currently, the system is straddling two benefits. Risperdal and Invega are part of the medical benefit and are billed directly by providers. Haldol and Prolixin are billed by the pharmacy. The goal is to be able to offer these physician administered drugs as both pharmacy and medical benefits. The pharmacy benefit would only be administered by a specialty pharmacy; there are special restrictions and guidelines on storage and administration of the drugs. This will not occur for July 1, 2012; however, the state departments will continue to work together toward this goal. Long-acting injectable medications will be offered through the medical benefit for the scope of this project until the goal is met. Doug added that ODADAS has discussed the potential for addiction medications to be billed in this manner in the future as well.

Training Items

Angie reported that training items were identified when the focus groups met. The state is prepared to put together training approaches. She stated that the departments are planning to review the available written material on these topics and put the issues in the context of this transition for the training. The items identified below are also listed on slide 30 of the Power Point presentation. Angie emphasized that this is not yet a comprehensive list.

- General claim submission information and instructions
 - Date of service
 - MACSYS UCI and MITS Medicaid number
- Software requirements
 - 827P/835, TPL, and other requirements
- Hold and review process
 - EDI – use PWK segment in 837P to indicate supporting documentation is coming
 - MITS provider portal – provider uploads documentation
- Pharmacy requirements
- MACSYS member enrollment
- Eligibility Verification
 - MITS Provider Portal
 - EDI – 270/271 transaction set
- Prior Authorization
- Electronic Fund Transfer Requirements
- Web Portals
- Claim Correction Processes
 - MITS Provider Portal
 - EDI – 837P

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Doug stated that providers will need to make sure that their vendors can perform the hold and review process functions; even though this will not be needed on a regular basis, the system needs to be able to accommodate it. Mary stated that ODJFS is currently cross-referencing OBM, ODMH, and ODADAS records to see how many providers already have bank account information on file and are registered in the OAKS system. She added that ODJFS is considering sending a reminder to providers to check to make sure they have current and accurate information in their EFT accounts. This information will be essential for providers to be paid.

Other Issues

Doug indicated that the UCI is used when billing MACSYS and the Medicaid ID is only used when billing MITS. Reason codes will be developed in Diamond that will be mapped to HIPAA compliant codes. He also reported that the state is conducting a provider-level analysis to ensure that each mental health and AoD provider has both the ODJFS Medicaid provider number and the NPI number.

Question: Is it possible that AoD providers will need to obtain another number? We are in the process of getting certified for AoD services, so we will not be in the system yet.

Answer: Doug stated that the departments are looking into this issue now. He requested that the individual asking this question contact him after the meeting to discuss further. He stated that the departments will need to look at this issue from the individual provider's perspective; they will probably need a unique UPI for each type of service.

Director Plouck stated that a transition process will be needed when Medicaid billing moves to MITS. She would like to continue to offer an augmented level of support from the MACSYS Support Desk around the transition. The department will need to look into the possibility of providing support beyond what is provided by ODJFS. She also stated that ODMH is committed to working with ODJFS and ODADAS on the board access to data issue.

Additional Questions and Answers

At this point the speakers took additional questions from participants.

Question: How will duplicate rules in MITS vs. duplicates in MACSYS with modifiers be handled?

Answer: Doug stated that due to the way that MACSYS adjudicates claims with modifiers, duplicates appear in certain scenarios. However, this does not occur in MITS; the system does not adjudicate in the same way by modifier position. The departments are implementing business rules that will look at the combination of HA/HF; it will be set up to mirror MACSYS as closely as possible. Kathy added that the SC modifier will no longer be needed to bypass limits, because the limits will not be applied to children in MITS. She also stated that the TJ modifier will be implemented in MITS. Prior authorization will still be required for partial hospitalization and CPST.

Question: Will MITS payment reporting identify specific claims paid either in the 835 or separately for batch control?

Answer: Doug stated that he will follow up on this question after the meeting. He requested that the person who asked the question submit clarification about it so that he can better understand what is needed.

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Question: Will MITS accept a combined MH and ODADAS claim file?

Answer: Doug stated that this has not been tested, but he believes it can be done. The UPI and ODJFS numbers would need to align for it to work.

Question: At the beginning of this session, it was stated that only Non-Medicaid clients will be enrolled with the Boards. No Medicaid clients need to be enrolled. Why would the Boards need to be involved with a pure Medicaid client for whom they are not paying?

Answer: Doug stated that there are probably good reasons to enroll or not enroll; ultimately, providers are not required to enroll Medicaid clients through the board in order to receive reimbursement for services.

Question: Are out of county boards required to enroll and pay for non-Medicaid clients in MACSYS for Crisis Intervention Services after 7/1/12? What is the agency recourse if the out of county board fails to provide a UCI number?

Answer: Angie stated that the mental health policy related to 72 hour crisis will not change. ODMH will issue guidance related to residency disputes.

Question: What is the normal turnaround time for an 835 to be generated for claims on 837 in MITS?

Answer: Mary stated that she believes that ODJFS processes claims weekly. The system adjudicates claims more quickly, but the financial cycle runs weekly. Depending on which day the claim is submitted, turnaround time is approximately 7 to 10 days.

Question: From my understanding, we can only manually bill 55 claims in MITS per day, will that change? If so, what will be the cut off?

Answer: Mary stated that she will follow up on this question. She will either confirm that it is changing or find out whether options exist to do so.

Question: We saw information on ODJFS' website stating they weren't accepting new Trading Partners. Is that true, or is it a mistake on their website?

Answer: Mary stated that this is old information that should not appear on the website. ODJFS is currently working on removing it.

Question: Is there an ODJFS transaction guide for 270/271?

Answer: Mary indicated that this guide can be found on the resource page of the Power Point presentation distributed today. Doug added that the resource page also provides information about web pages that include a section about trading partner agreements.

Question: What is the timeline for the TP Agreement? I heard four months, not two weeks. Any thoughts?

Answer: Doug stated that the time frame depends on the file structure and testing time. Mary stated that if a new trading partner cannot satisfy requirements by July 1, 2012, they can use a clearinghouse. A list of clearinghouses and all ODJFS certified trading partners can be found on the resource list in the presentation as well.

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Question: When can providers start setting up trading partner agreements?

Answer: Mary stated that providers should begin this process as soon as possible. She added that ODJFS has never had such a large number of providers enrolling as their own trading partners and this may slow the process down a bit. Doug added that there are two components to establishing a trading partner agreement. First the application is submitted electronically, and then a legal document must be signed, which is a paper driven process that happens after the trading partner agreement number is assigned. Both Mary and Doug emphasized the importance of beginning this process now.

Question: Will MITS deny claims submitted with dates of service prior to July 1, 2012?

Answer: Doug answered yes, these claims will be denied.

Question: How will roll up service work in ODJFS and how should straggler claims be handled?

Answer: Doug stated that roll up would still apply through using modifier combinations. Kathy stated that the straggler claims would need to be submitted as an adjustment to the original claim. This can be done either through EDI or the MITS portal.

Question: How do providers gain access to the MITS portal if they do not have it already?

Answer: Doug stated that all existing Medicaid providers who have an ODJFS provider number can access the MITS portal. He added that providers who do not know their provider numbers can contact either ODMH or ODADAS to obtain them. The link to the MITS portal will be added to the resource list on today's presentation.

Question: Can the boards refuse to enroll Medicaid clients into MACSYS after July 1, 2012?

Answer: Yes, boards are only required to enroll clients who are receiving non-Medicaid services for which the board is financially responsible.

Question: Will there be multiple training dates for the same topical training?

Answer: Angie stated that the departments are currently working on a training agenda and details are forthcoming.

Question: Has a decision been made on the need to enter clients into the BH system and level of care?

Answer: Doug stated that ODADAS is still working on this and no decision has been made. Currently, the key to getting a client in the system is the UCI number. ODADAS will provide more details as they become available.

Question: Is it correct that the SC modifier will not be used in MITS?

Answer: Yes.

Question: Given that most software vendors are still in development, does the state think that July 1, 2012 is a realistic deadline?

Answer: Angie stated yes, this is the state's goal.

Question: Will there be a plan B if the deadline cannot be met?

Answer: Angie responded that the state continues to discuss many different feasible options in

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the event that it would not be prudent to move forward on July 1, 2012. It is understood that a plan B is needed, but the state is not ceasing working toward the goal of being ready on July 1, 2012.

Additional Questions and Answers Via Web

The questions below were submitted electronically but not addressed during the webinar. Answers were added after the session.

Question: Will RA/RJ/ERA files continue through payments for FY 12 services or report date?

Answer: No, RA/RJ/ERA files will be discontinued as of 7/1/2012 no matter the date of service.

Question: When RA's are discontinued, how will we receive the payment information?

Answer: Payment information will be disseminated on the HIPAA Compliant 835 payment file.

Question: If we submit 4 daily claims and the weekly payment does not match expectation, how will we know what claims are included? This is now on the RA.

Answer: In MITS, a claim is either paid or denied. This information will be reported on the HIPAA Compliant 835 payment file.

Question: Regarding 835. We are currently receiving 835s from 2 counties. The other counties send us, via fax or mail, RA/RJ. Our patient accounting area MUST be able to match the checks received with the RA/RJs in order to apply payments to correct accounts. Will it be up to the individual counties to continue to create a report for pre 7/1/12 claims (after (7/1/12)?

Answer: The payment process for claims with dates of service prior to 7/1/12 will remain the same except the RA/RJ/ERA files will no longer be created by the state. Providers will receive 835 payment files from each county they expect to receive payment.

Question: What if a Medicaid client loses Medicaid? Will we be able to enroll the clients with our local board at that time?

Answer: Yes, if you contract with that board for non-Medicaid services and the board accepts financial responsibility for the client.

Question: Will every mental health client continue to be enrolled in MACSYS after July 1, regardless of Medicaid status? Will they all receive a UCI?

Answer: There is nothing that prevents boards from enrolling Medicaid clients in MACSYS after 7/1/12. The state is looking at the feasibility of enrolling all Medicaid clients who are eligible for behavioral health services in MACSYS via an automated process.

Question: Will there be minutes with questions and answers that were covered today? We could not hear a lot of the answers.

Answer: Yes, minutes will be made available and be posted to the ODMH web site at:

<http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/macsis/macsis-mits-claims-processing.shtml>