OKLAHOMA Health Care Authority

MEDICAID CONSTITUENTS

MEMBER

SINGLE ADULT
Linda Johnson
Linda is a 39-year-old Oklahoma native working as a general contractor in construction. The job is hard on her arthritis and she struggles with anxiety, but it's been hard to prioritize healthcare when she's worried about food security.

PROVIDER

PRIMARY CARE CLINIC
Glenn Smith
Glenn is the administrative director of a large primary care clinic in Oklahoma City, with over 20 years of clinical experience as a former physician. While his practice is committed to improving health equity and access for all patients, participating in Medicaid adds complexity to the clinic's operations.

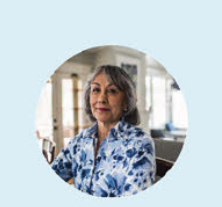
CONTRACTED ENTITY (CE)

CE PROGRAM MANAGER
Brandon Little
Brandon is a program manager at a major payer (CE) who has been tasked with developing and expanding the CE's Medicaid presence in Oklahoma. He has led similar efforts in other states and knows how much work it takes to serve the Medicaid population, so he is focused on setting up his team for success.

COMMUNITY BASED ORG (CBO)

CBO COORDINATOR
Claire Emerson
Claire is the program coordinator for a large network of CBOs that support disadvantaged communities. Her org helps address social determinants of health (SDOH) and works extensively with nonprofits, charities, and faith-based organizations.

AGENCY



OHS PROGRAM DIRECTOR
Joanna Redding
Joanna has worked at Oklahoma Human Services for 20 years, originally as an eligibility and enrollment agent and now managing our non-MAGI (Modified Adjusted Gross Income) Medicaid programs. She cares deeply about doing what it takes to do the right thing for our clients and community.

OHCA

OKLAHOMA Health Care Authority

SYSTEMS & TOOLS
MMIS Existing MMIS Systems and Tools
OTHER Other Systems, Tools, and Data Sources

OHCA FUNCTIONAL TEAMS

PROGRAM PLANNING

Assess Population Needs

PROVIDER

Glenn is approached by former colleagues who now work for CEs that are looking to enter the Medicaid market in OK. They're looking to gauge whether Glenn's practice is interested in contracting with their CEs.

Glenn has a good relationship with these colleagues and after several discussions, he signs letters of agreement (LOAs) with two of the CEs on behalf of his practice.

PRIMARY CARE CLINIC

LONG-TERM CARE FACILITY
Amy Bernard
Amy is the executive director of a nursing home located in Tulsa. Having grown up with a grandmother who was diagnosed with Alzheimer's, she saw firsthand how long-term care facilities can help patients continue to live a full life, and she has built her entire career around long-term care.

Amy is approached by the former head of the local hospital that partners closely with Amy's nursing home, who now works for a CE looking to enter the Medicaid market. Amy knows this person understands the needs of her facility very well and feels comfortable signing a letter of agreement with the CE on behalf of the nursing home.

FQHC
Allison Murphy
Allison is the CEO of a federally qualified health center (FQHC) located in rural southeast Oklahoma. She is passionate about serving disadvantaged communities, but finds it challenging to keep the FQHC running given budget and resource constraints.

Allison is approached by the former head one of the largest FQHC networks in Oklahoma, who now works for a CE looking to enter the Medicaid market. Allison agrees to facilitate a meeting with her FQHC's governing board of directors. After discussions, the board signs a letter of agreement with the CE on behalf of the FQHC.

CONTRACTED ENTITY (CE)

Brandon, the program manager at a CE, gets his team prepped to enter the OK Medicaid market.

In anticipation of OHCA releasing an RFP, Brandon and his team start conversations with key stakeholders at the state to discuss the needs of OK's Medicaid population and understand the state's requirements on provider mix/credentialing. For the next 2 years, Brandon and his team continue to build relationships with the state, providers, and CBOs.

Brandon stands up a large team to gauge interest among providers and collect signed letters of agreement from providers open to contracting with the CE.

- 👎 I wish it was easier to understand how I can differentiate my CE's provider network with the state
- 👎 Upfront investment to build these provider relationships is risky since there is no certainty that they will lead to any ROI
- 👎 Working with FQHCs and tribal populations requires access to specific community champions to engage these providers
- 👎 Gathering signed letters of agreement with the different providers is a large effort and requires significant resources
- 👎 It's challenging to balance the right mix of national and local CBOs. I wish it were easier to get involved with local CBOs.

COMMUNITY BASED ORG (CBO)

Claire's organization is a community care hub and referral network for local CBOs with partnerships across Oklahoma, and many of the communities she helps overlap with the Medicaid population.

To better serve her population of CBO users, Claire sends an email to the OHCA community partner inbox to sign up as an official OHCA partner, hoping this will give her organization more access to Medicaid resources.

Claire is notified that she's been added to the OHCA community partner distribution list, but it's not clear what additional benefits this brings, aside from an occasional webinar on Medicaid topics.

She shares what she is hearing from Medicaid applicants/members using her network's CBO resources, via the same OHCA community partner inbox, but never receives a response.

- 👎 I wish my organization and/or the CBOs I work with had more input to the development of Medicaid services and communications. We are in the front lines with members everyday
- 👎 The benefits and impact for my organization becoming part of the OHCA partner community are still unclear
- 👎 There is no effective platform for us to provide feedback to the state on the insights we are learning

AGENCY

In her role at OHS, Joanna works with OHCA to manage eligibility and enrollment for the non-MAGI Medicaid populations, as well as supporting Medicaid Waiver programs and providing input on Children's Specialty Program needs.

OHCA and OHS work together to improve services for the Aged, Blind, Disabled (ABD) population like those through the ADvantage care management waiver program. Joanna shares data from OHS with OHCA on this population's needs to inform a shared strategic vision for the population.

Separately, as CEs reach out to OHCA to learn more about the state's Medicaid program needs ahead of an RFP, Joanna provides her perspective on non-MAGI populations under managed care (e.g., children in foster care).

- 👎 We have siloed systems across departments, so it's hard to get the data that I need to make decisions without manual workarounds
- 👎 I wish that our agencies took the time to more consistently and comprehensively plan services for shared populations

ⓘ **OHCA MAGI Medicaid Population**
Meet citizenship and income guidelines, and in one of the following categories:
- Children
- Pregnant women
- Low-income non-disabled adults with children
- Seeking family planning services
- Not eligible for Medicare
- Employed at company enrolled in InsureOK
- Aged out of foster care in another state

ⓘ **OHS Non-MAGI Medicaid Population**
Meet citizenship and eligibility requirements and are in one of the following categories:
- Aged (over 65), Blind (any age) or Disabled adults
- Disabled children who do not qualify for SSI
- Reside in nursing home
- Require Medicare cost-sharing assistance
- Home and community-based waiver population
- Children in OHS custody
- Receive tuberculosis treatment

ⓘ **Other state agency populations that overlap with Medicaid**
- OHS: Recipients of Economic Assistance Programs (e.g., SNAP, TANF, etc.), child support, children in foster care
- OSDH: WIC participants
- OJA: Youth in OJA Custody, including in-home, out-of-home and pre-adjudication detention center placements
- ODMHSAS: Individuals receiving state-run mental health or substance abuse services

OHCA

OHCA meets regularly with other agencies to understand the needs of the Medicaid populations that they serve. They also meet with potential CEs and CBOs to learn more about their service offerings and how they might meet the needs of their Medicaid populations. This information helps OHCA define requirements for new CE RFPs.

- 👎 I wish it was easier to know who/what division to contact at OHS to engage in joint program planning due to the agency's size and complexity

SYSTEMS & TOOLS
MMIS Business Objects
MMIS Claims Processing
MMIS Data Warehouse
MMIS iCE MMIS
MMIS Provider Portal
OTHER eQSuite
OTHER Tableau

OHCA FUNCTIONAL TEAMS: Quality · Case Management · Policy

Design Services & Provider Network

PROVIDER

Glenn's contacts at the CEs let him know they've won the bid for Medicaid and in order to move forward, Glenn's practice needs to enroll with OHCA. This includes an application for the entire practice as well as individual applications for each physician and nurse.

Glenn submits the provider enrollment application for the practice on OHCA's website and uploads the relevant documentation. While submitting the application, he has issues uploading a key document and has to call the OHCA helpline to get assistance. His issue is resolved, and the application is submitted.

After not hearing anything for over 4 weeks, Glenn wonders what the status is on the provider credentialing. When he calls the OHCA provider helpline, he is told it's still processing but no additional action is needed. He later receives a notification that his practice is approved as a Medicaid provider and signs a service contracting agreement with OHCA.

Throughout this enrollment process, Glenn negotiates potential rates and coverage policies with each CE. He's able to reach favorable terms with two CEs and signs service contracting agreements with them.

ⓘ Glenn's practice can submit retroactive Medicaid claims for services administered to Medicaid members while his contract was processing

Every year thereafter, Glenn is required to complete the contract renewal process, though he typically doesn't complete it until near the deadline.

- 👍 It's great that provider enrollment is fully digital and online
- 👍 I appreciate how hard everyone is working behind the scenes to help resolve processing/systems challenges
- 👎 I wish the provider portal wasn't so glitchy - sometimes I get kicked out mid-application or I get documentation upload errors
- 👎 I wish it was easier to see the status and expected processing time of my application in the provider portal
- 👎 I wish the application instructions were clearer
- 👎 I wish my renewal applications were processed faster, so there wasn't uncertainty on whether I will be reimbursed for services provided

LTC · FQHC

Since Amy and Allison work at facilities that involve higher levels of risk, their facilities require an onsite visit with OHCA as a prerequisite for approval.

ⓘ Provider types that require site visits include (not exhaustive): behavioral health agencies, hospice, laboratories, physical therapy groups, and home health

- 👍 The site visit process was easy to schedule and relatively straightforward

CONTRACTED ENTITY (CE)

An RFP is released by OHCA and awarded to Brandon's organization.

Brandon and his team must meet network adequacy 6 months before launch. They begin the process of converting provider LOAs into contracts, which includes conducting provider checks/credentialing and negotiating Medicaid premiums.

At the same time, Brandon must build out a local care management team for the CE. To support care management, Brandon and his team search for CBOs to provide wrap-around services and support that address SDOH and focus on whole-person health.

On an ongoing basis, Brandon continues contracting new providers and CBOs to maintain network adequacy as needed.

ⓘ Common wrap-around CBO services needed include transportation, food services (e.g., meal delivery), custodial care (e.g., help bathing, grocery shopping), housing repairs (e.g., leaky roof, broken staircase, heat/water), and pest eradication (e.g., rat infestation)

- 👍 It's easy to understand what the state's requirements are for their network
- 👎 I wish we weren't under such a time crunch after winning the RFP - we have to scramble to build an entire org and infrastructure in the next 9-12 months
- 👎 Low Medicaid reimbursement rates make it difficult to contract with providers
- 👎 We have little to no negotiating power with providers (hospitals in particular)
- 👎 We don't have enough traction with specialty providers (e.g., long-term care, behavioral health) and it's particularly difficult in rural or out-of-state locations
- 👎 I wish there was a better way for us to get comfortable with the risks associated with custodial services, which has potential for abuse and fraud

COMMUNITY BASED ORG (CBO)

- 👎 I wish it was easier to get access to Agency View - it took us 6-9 months

AGENCY

OHCA asks Joanna to participate in the Medicaid CE vendor selection process. She helps review RFP responses and provides an OHS perspective.

For the Medicaid fee-for-service program, Joanna works with the OHS/OHCA network team to assess and refresh provider network adequacy. In the middle of this refresh, Joanna discovers that DMH has made a change to their budgetary policies for behavioral health services, which impacts reimbursement rates and service coverage for both OHS and OHCA's Medicaid populations.

- 👎 I wish policy-setting and strategic planning processes and governance across state agencies was more collaborative and coordinated

OHCA

OHCA develops, posts, and awards Medicaid managed care RFPs, with input from other state agencies (e.g., OHS, DMH) and OHCA teams (e.g., Legal, Policy, Quality) as appropriate.

OHCA manages and maintains the provider network/directories and associated provider contracts for both MAGI and non-MAGI (OHS) populations.

OHCA Provider Call Center
A Tier 1 Provider call center agent picks up Glenn's call and transfers Glenn to a Tier 2 agent who can handle document upload issues.

The Tier 2 agent realizes that there are no call notes attached to the transfer and has to ask Glenn to repeat his issue. During the call, the agent runs into a system error which forces her to restart the enrollment application multiple times, turning a 5-minute task for Glenn to take 20-30 minutes to resolve. The Tier 2 agent is able to eventually help Glenn resolve the document upload glitch and tells Glenn that his application should be processed shortly.

Several weeks later when Glenn calls again to check on the status of his application, a different Tier 2 agent realizes that Glenn's application won't upload to the iCE MMIS system due to an error. After reassuring Glenn that his issue will be escalated, the Tier 2 agent emails an OHCA systems analyst who will follow up with Gainwell.

OHCA Provider Education Team
A member of the provider education team reaches out to Amy and Allison to schedule and complete an onsite review, given their facilities' higher level of risk.

- 👎 I wish our system was more flexible with documentation uploads. A lot of calls are dedicated to helping providers work around these restrictions
- 👎 I wish provider applications didn't have so many system errors [redacted] They cause major delays
- 👎 It's not uncommon for my system to glitch and force restart, sometimes multiple times during a single task, resulting in a simple contract update taking 20 to 30 minutes
- 👎 I wish there was a standard way that our call center agents documented transfer notes, so I could more efficiently help callers
- 👎 I wish that we had a tool to help our legal and provider contracting teams collaboratively track and manage provider contracts and renewals in a timelier manner

SYSTEMS & TOOLS
MMIS Business Objects
MMIS Data Warehouse
MMIS COLD
MMIS Provider Portal
OTHER RightFax
OTHER Tableau

OHCA FUNCTIONAL TEAMS: Legal · Policy · Provider Enrollment · Quality

Secure Funding

AGENCY

In order to move forward with the agreed improvements for the ADvantage waiver program, Joanna is asked to help complete the 1915(c) waiver process that must be submitted by OHCA to receive federal approval and funding.

Joanna goes back and forth between OHCA and multiple OHS divisions to determine how to fund program changes and which state budget for various waiver programs is managed.

- 👍 I appreciate my OHCA colleagues going above and beyond to help us develop the waivers
- 👎 I wish it was easier to collaborate across agencies on CMS funding requirements (e.g., waivers, Advanced Planning Documents)
- 👎 I wish program budget and management were more aligned with the operational responsibilities across various state agencies

OHCA

OHCA is accountable for completing CMS Advanced Planning Documents (APD) to receive federal approval and funding for technology to support their Medicaid Programs. However, OHCA often requires input from partner agencies such OHS, OJA and ODMHSAS for the Medicaid waiver programs that they manage or support.

- 👍 I'm proud of our team's willingness to step outside their role/responsibilities to "get things done"
- 👎 I wish that we had a dedicated budgeting tool, instead of using Excel
- 👎 I wish there was a better way for us to get the input we need from other agencies to meet CMS requirements

SYSTEMS & TOOLS
MMIS Business Objects
MMIS Data Warehouse
MMIS Provider Portal
OTHER Great Plains
OTHER PeopleSoft
OTHER Tableau

OHCA FUNCTIONAL TEAMS: Policy · Business Enterprises · Executive Leadership

Launch Service

PROVIDER

Once all of the providers in his practice are registered, Glenn ensures they all have access to the OHCA Provider Portal and are assigned their own PIN.

He collaborates with OHCA's Provider Education Specialists in scheduling various onsite and virtual trainings for his practice's providers and administrative staff. His large practice uses a 3rd party medical billing clearinghouse. He ensures that they are also included in OHCA education and training, so they are prepared to handle Medicaid claims and payments.

He works with his practice's operations team and IT department to ensure that the practice is able to meet state compliance requirements related to quality measures and health indicators.

- 👍 I appreciate how OHCA's Provider Education Specialists customize the trainings and are hands-on with my team, walking them through real examples
- 👎 I wish that we didn't have to provide duplicative data and contract details to CEs across all the health plans with whom we contract
- 👎 I wish it was easier to align our systems to meet plan reporting requirements
- 👎 It's difficult to get my physicians to engage in trainings and administrative tasks related to Medicaid in addition to clinical responsibilities
- 👎 I wish there was more support for rural or small town providers on processes and technology requirements for Medicaid

FQHC

Since Allison's clinic also files claims and prior authorizations for more complex specialties, including pharmacy and behavioral health, she requests additional training from Provider Education Specialists around filing and coding for related claims and prior authorizations.

- 👎 It's very costly hiring an external team to set up the health and quality data tracking required by OHCA and CEs, since we don't have the in-house capabilities

CONTRACTED ENTITY (CE)

To prepare for launch, Brandon and his team begin building out and testing the technology infrastructure with a focus on provider database management (PDM) - this includes building the provider directories, business rules/pay class loads for claims/billing accuracy, and more.

During this time, Brandon and his team create marketing materials for their plan for OHCA to approve. As the launch date nears, Brandon and his team conduct relevant trainings for state and provider stakeholders, establish call center support to assist with member onboarding, and train their care managers.

About 3-4 months before launch, Brandon's team initiates readiness reviews with OHCA for CMS submission. Following approval by CMS and OHCA, the program goes live.

ⓘ CEs plan and test for several potential barriers to enrollment, including language barriers, technology accessibility issues, and general form completion issues

- 👎 PDM is a nightmare to manage, and I wish the quality of data we received from the previous CE and the state was better
- 👎 We are not training our care managers early or well enough before go-live to handle member calls

COMMUNITY BASED ORG (CBO)

One of the CBOs in her network is focused on home meal delivery. Claire and the CBO discuss potentially applying to become a certified provider in the Medicaid ADvantage waiver program managed by OHCA and OHS. The reimbursements would go a long way to help fund CBO operations.

The online application is easy to find and quick to complete, but Claire worries that the conditions for participation, quality controls, and reporting requirements may require too much time and technology infrastructure that the CBO does not have.

- 👎 I wish CBOs had the capacity, processes and infrastructure to scale-up core services and meet the requirements for collaborating with CEs and other state agency programs to serve people in need
- 👎 I wish we had support to identify and apply for grants or secure other funding sources to help us meet the overwhelming demand for services
- 👎 I wish there was an easier way to provide state agencies with the data and outcomes they're asking us to track to demonstrate ROI and impact

AGENCY

Joanna participates in workshops with her OHCA and IT counterparts to understand the processes and data that will need to be shared across their agencies related to the eligibility, enrollment and management of the non-MAGI Medicaid population. They also work to identify cross-training needs for the eligibility and enrollment teams, as well as other OHS divisions who work with these populations (e.g. foster care, ABD).

After the workshops, Joanna works within OHS to develop required materials for training, marketing, and member onboarding. Additionally, Joanna connects with other OHS division leads to support cross-program eligibility and enrollment (e.g., SNAP, TANF).

- 👎 I wish agencies had more consistent levels of technology and infrastructure maturity, which would enable better cross-agency program implementation
- 👎 I wish we better coordinated marketing and communications planning across agencies and programs

OHCA

OHCA works across state agencies to identify and execute on needs related to system infrastructure, data sharing interfaces, workforce training, and marketing/onboarding materials and communications for members and providers.

OHCA Provider Education Team
An OHCA Provider Education Specialist checks the team's dedicated inbox and sees training requests from Glenn and Allison. The specialist reaches out to both providers to learn more about their needs and arranges for live training.

- 👎 We could do a better job coordinating with our agencies on developing a communication strategy and plan
- 👎 I wish the reports that CEs send us for compliance were more automated and standardized - we're often receiving spreadsheets
- 👎 I wish that our agency had centralized technology and data governance
- 👎 I wish we had established guardrails for acceptable data discrepancies
- 👎 I wish that we had a system to track and manage data requests between and across agencies
- 👎 I wish that we had dashboarding capabilities with real-time data to provide more transparency into program performance
- 👎 I wish that we had better HR insights to understand our current talent and skills, assess gaps, and provide appropriate training

SYSTEMS & TOOLS
MMIS Business Objects
MMIS Data Warehouse
MMIS Initiate
MMIS Letter Generator
MMIS Member Portal
MMIS Provider Portal
OTHER Tableau

OHCA FUNCTIONAL TEAMS: SoonerSelect · Provider Enrollment · Member Eligibility & Enrollment · Legal

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ENROLLMENT / RE-ENROLLMENT

Build Awareness

MEMBER

SINGLE ADULT

Linda hasn't seen a doctor in years and wants to prioritize her health because it's starting to affect her job as a construction worker.

She sees some flyers at her local food bank about accessing Medicaid through OHCA. She thinks of the flyers when a coworker suggests checking out Medicaid for her arthritis, since her job doesn't offer health insurance and doctors are so expensive.

Linda decides she'll do some research on Medicaid after picking up food parcels from a local food bank that will help her get through the week.

- 👍 It was easy to find high level information about the Medicaid program
- 👎 I wish it were easier to look up all the different types of state programs and local resources available to me in one place

TRIBAL MEMBER
Kaya Wolf
Kaya is a 26-year American Indian woman who runs a residential cleaning service. Over the years she has become a more active member of her tribe, and she wants to find doctors who understand her culture and values.

Kaya hears about Medicaid through her friends and community leaders in her tribe. She wants to find a PCP who understands tribal healing and decides to attend a Tribal Health Fair where she learns more about Medicaid from an OHCA representative.

PARENT/GUARDIAN AND CHILD
Sara McBride/Jamie
Sara is a 42-year-old single mom balancing work as a cashier and caring for her foster son Jamie who has asthma. She spends much of her time navigating the ins and outs of different state agencies on Jamie's behalf.

During an event hosted by OHS focused on supporting foster parents, Sara learns more about the benefits Medicaid offers to foster kids.

PROVIDER

Glenn ensures his practice's intake staff are trained and prepared to inform uninsured patients about Medicaid and help them with the enrollment process.

ⓘ Throughout the reception area, OHCA Medicaid brochures and materials are featured for those who want to learn more

- 👍 By signing up uninsured patients for Medicaid quickly and on the spot, my clinic can reduce the amount of uncompensated care
- 👍 OHCA does a great job providing Medicaid resources and materials for my department, ensuring we have what we need to educate our patients

HOSPITAL ED
Trisha Howell
Trisha is a physician in the emergency room of a hospital in Norman. While her role in the ED is stressful, she is proud of the lives her team has impacted, especially the newborns her ED has helped deliver and transition into Medicaid's Soon-To-Be-Sooners program.

Trisha's department ensures that uninsured pregnant mothers who enter her emergency room are counseled by hospital staff on the programs and services that are available to her, including Soon-To-Be-Sooners providing services for the unborn child, or ensuring the mother and her newborn in are enrolled in Medicaid after birth.

The Medicaid agents that Trisha's department employs receive payment contingent on the number of individuals they sign up for Medicaid.

FQHC

Given the high number of patients who are uninsured and from underserved communities who visit the FQHC, Allison equips her staff with educational materials about state programs (e.g., Medicaid, WIC and CBO resources.

She also hires a 3rd party vendor to assist with Medicaid counseling and enrollment.

CONTRACTED ENTITY (CE)

Brandon and his team continue to leverage the relationships they have built with providers and local community champions, along with developing proactive marketing campaigns, to raise awareness among applicants and the Medicaid population. The team makes educational materials and plan resources available through general search engines (e.g., Google, Bing) and the OHCA website.

COMMUNITY BASED ORG (CBO)

Shortly after the launch of the Medicaid program, Claire receives an invite for an eligibility webinar hosted by OHCA for community partners. Claire and her team are trained on the OHCA Home View Application, so they can help CBOs and the people they serve to set up their account and apply for Medicaid.

Claire and her team incorporate Medicaid content that is available on the OHCA website into their community outreach, events, and include links on their website.

- 👎 I wish there was more dedicated content on Medicaid eligibility requirements and the enrollment process for CBOs and community partners to leverage
- 👎 I wish it was easier to navigate state agency websites for information on Medicaid and other supplemental programs

AGENCY

Joanna provides the OHS eligibility/enrollment team and case workers with materials and training about upcoming changes to the Medicaid program for non-MAGI members.

Joanna also works with OHS IT to make sure Medicaid program changes are reflected on the OHS website.

- 👎 I wish updates to the OHS website were approved, designed and implemented faster and delivered a more seamless constituent experience

OHCA

OHCA posts information to their website to inform potential members, partners, providers, and the community about the new program or program changes

- 👎 I wish that our OHCA Communications team could get communication analytics (e.g., text messages, emails, social media) to assess how best to reach the different populations that we work with

SYSTEMS & TOOLS
MMIS Business Objects
MMIS Data Warehouse
MMIS Initiate
MMIS Letter Generator
MMIS Member Portal
MMIS Provider Portal

OHCA FUNCTIONAL TEAMS: Legal · Policy · Quality Data & Analytics · Communications · Member Eligibility & Enrollment · Provider Enrollment · Finance

Confirm Eligibility

MEMBER

Linda searches for Medicaid online and is directed to the OHCA website to learn about eligibility guidelines. She decides to apply for benefits. She sees an option to apply through OHCA or OHS and picks OHCA because the criteria seems to fit her scenario best.

It takes her a long time to understand the Medicaid application, but she fills it out as best she can and submits on the OHCA website. Her application is approved that same day, and she is prompted to submit documentation to finalize the approval. Confused about the type of documentation she needs to submit for income eligibility, she calls the OHCA member helpline to get assistance and waits a long time before getting through to someone who can help her submit all the required documents.

Linda was hoping to find information about food assistance programs like SNAP, but is unable to find what she needs. After clicking through several pages on the OHCA website, she opens a new search on her browser instead and is directed to apply separately through OHS (OKDHSLive.org). Here, she sees a number of programs she could be eligible for, including Medicaid.

After some time, Linda is notified that her Medicaid and SNAP applications have been officially approved.

ⓘ If an application is denied, members can call for a denial reason and appeal the decision by filing a member complaint or grievance form

At the end of the year, Linda is asked to submit documentation to re-confirm eligibility for both Medicaid and SNAP.

- 👍 I was surprised my application got approved so quickly - the same day I applied!
- 👍 Call center reps are friendly, empathetic, and work hard to get me the help I am looking for
- 👎 I wish the application was easier and more straightforward - I'm afraid of making mistakes
- 👎 I didn't understand all the automated options when I called the helpline and then had to wait 60+ minutes to talk to someone
- 👎 I submitted my docs 2 weeks ago, and I have no idea what the status of my application is
- 👎 I wish I didn't have to apply through different applications for all these programs, when I'm filling in the same info each time
- 👎 I get so much mail from the OHCA that I missed the letter to reapply for Medicaid and now my benefits are delayed
- 👎 When it's time to re-enroll, I have to update my eligibility over the phone; I wish I could do it online
- 👎 I wish the state would send me a single letter with all of my programs instead of ones from each agency separately

ABD INDIVIDUAL
William Boykins
William is a 35-year-old member of the Aged, Blind, and Disabled (ABD) population who has lived with cerebral palsy all his life. Maintaining independence is important to him, and his Medicaid care manager and family have helped him stay out of long-term care.

William starts to apply online through OHCA only to be prompted halfway through the application that he needs to start over and apply through OHS.

When William calls the member helpline, it's someone from OHCA picking up who explains the difference between the OHCA and OHS application and transfers him to a OHS representative to complete the rest of the application over the phone.

- 👍 I love that OHS automatically screened me for eligibility to other OHS programs and services
- 👎 I wish it was more clear whether I should use OHCA or OHS to enroll
- 👎 I wish the OHCA and OHS websites were easier to use and navigate - the user experience feels dated and disjointed

ELDERLY/ADULT CAREGIVER
Maria Gonzalez
Maria is the primary caregiver for her 75-year-old mother and single mom to 2 teenage children. She cares for her mother at home but as her mother's health worsens, Maria wonders if long-term care is the better option.

Maria navigates to OKDHSLive to apply on behalf of her mother.

TRIBAL

Kaya visits the closest Indian health center to get assistance with her application. She is required to provide a CDIB card and a tribal enrollment card as proof of eligibility.

COMMUNITY BASED ORG (CBO)

As many local CBOs help eligible individuals apply for Medicaid and other state agency programs, Claire's staff realize many aspects of these applications are confusing and difficult to read and understand.

Claire's staff call the OHCA member helpline and email questions through OHCA community partner inbox to confirm they are giving applicants accurate information.

- 👎 I wish there was a dedicated OHCA partner helpline or communication channel to get answers faster
- 👎 I wish OHCA and other state agencies would consider testing/refining the language in applications with CBOs - we are on the front lines with people who need help from these programs

AGENCY

Joanna's team of OHS call center eligibility and enrollment agents help people like William and Maria complete their Medicaid application and interview over the phone. The eligibility agents determine that William and Maria are both eligible for SoonerCare, as well as other OHS programs (e.g., SNAP, TANF).

On a daily basis, OHS sends non-MAGI approval decisions to OHCA so they are uploaded in the MMIS. This includes enrollments for children in foster care, like Jamie, who are automatically eligible.

- 👍 I'm happy that we only have to process one eligibility screening for multiple OHS programs
- 👎 I wish we could offer same-day, paperless eligibility the same way OHCA does
- 👎 I wish eligibility and enrollment for all OHS programs (including non-MAGI Medicaid) was less manual

OHCA

OHCA Member Call Center
OHCA reviews applications and determines eligibility for the MAGI population, such as Linda.

When Linda calls the OHCA member helpline with a question about accepted documents for income eligibility, a Tier 1 OHCA member call center agent picks up, takes her information, and routes her to a Tier 2 call center agent on the member eligibility and enrollment team who is able to help Linda.

After helping Linda, the Tier 2 call center agent picks up the next call with William. Because William is a non-MAGI individual, the call center agent transfers him to the OHS call center to complete his Medicaid application.

Towards the end of the day, the Tier 2 call center agent focuses on her assigned workflow items, which includes manual document review and file tagging

- 👎 I wish our call/phone systems didn't have so many audio issues (e.g., poor quality, dropped/disconnected calls)
- 👎 It's so frustrating and time consuming when I get system reboots/forced restarts and have to reopen 10-15 screens
- 👎 I wish it wasn't a manual process to tag and assign uploaded documents in a member's application
- 👎 I wish that there was a chat option for quick questions to redirect call volumes
- 👎 I wish that we could warm transfer members to ensure that they get to the right person

SYSTEMS & TOOLS
MMIS Agency View
MMIS Business Objects
MMIS COLD
MMIS CTI
MMIS Data Warehouse
MMIS iCE MMIS
MMIS Initiate
MMIS Letter Generator
MMIS Member Portal
MMIS PASRR System
MMIS SAVE
OTHER DX Wages
OTHER IMS
OTHER OK Tax Commission
OTHER Qualtrics
OTHER RightFax
OTHER SSA

OHCA FUNCTIONAL TEAMS: SoonerSelect · Member Eligibility & Enrollment

Select Plan

MEMBER

Linda compares the benefits of each SoonerSelect plan she's approved for and calls the SoonerSelect Choice Counselor helpline to clarify her questions before making her final selections. After speaking with the counselor, she picks a dental plan and a health plan offered under SoonerSelect.

- 👍 My SoonerSelect Choice Counselor was very good at explaining the differences between plans in a way I can understand and helping me select the best plan for my needs

GUARDIAN: Jamie is automatically enrolled in the SoonerSelect Children's Specialty Program (CSP) as a part of the foster care program.

ABD · CAREGIVER: William and Maria's mother are enrolled in SoonerCare Traditional, since they are not eligible for SoonerSelect.

TRIBAL: Unsure of which plan to choose, Kaya enrolls in SoonerCare Choice since most of her community is enrolled in this plan.

COMMUNITY BASED ORG (CBO)

- 👎 I wish we had the ability to help applicants pick a plan or PCP in Agency View

SYSTEMS & TOOLS
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OHCA FUNCTIONAL TEAMS: Business Enterprises · Member Eligibility & Enrollment

Onboard

MEMBER

Linda receives onboarding resources from the CEs (SoonerSelect plans), including a contracted provider directory, benefits guide, and member handbook. As part of onboarding, she also submits required patient information to the CE, such as basic contact information, a health assessment, and other SDOH information.

Linda receives a separate set of onboarding materials and login information from OHS for her SNAP program.

- 👎 I've been approved for some programs and now have to use different apps to manage them all, which is overwhelming and takes a lot of time

GUARDIAN

Sara receives a login for the Health Passport from Jamie's OHS case worker, where she can see medical records for Jamie.

As part of her onboarding kit, she receives information about the SoonerSelect Children's Specialty Program and is reminded that when Jamie turns 18 he will no longer qualify and will need to apply for a different Medicaid plan. She also receives information from both OHCA and OHS encouraging her to schedule a well-child visit for Jamie.

ABD · CAREGIVER

William and Maria (on behalf of her mother) receive their onboarding materials from OHS, which includes the OHS provider directory. OHCA care managers reach out to William and Maria separately to better understand their needs for special assistance.

When Maria has trouble logging in to the member portal on behalf of her mother, she calls the OHS helpline only to be told she needs to be transferred to OHCA, which handles her benefits administration and account. The OHCA member helpline transfers her once more to the Internet Help Desk team.

- 👎 I am having issues logging into the member portal and was transferred several times before someone could help me
- 👎 I wish it was easier to call the member helpline outside of work hours - I don't have time during the day to do this

TRIBAL

Kaya finds out from a friend that she can find a PCP from a separate list for Indian health providers included in the OHCA Provider Directory

CONTRACTED ENTITY (CE)

As members begin signing up for the plan, Brandon keeps a close watch to make sure systems and processes are working as they should. He ensures that new member information is being populated (e.g., contact info, SDOH/health assessments, other lifestyle/risk factors) and that onboarding materials are being sent to new members (e.g., orientation kit, provider directory, benefits info, how-to guides).

- 👎 Contact information for members is often unreliable or out of date and it's hard to recollect and verify information

AGENCY

Joanna's OHS eligibility and enrollment team mails information packets to William and Maria's mother who have been approved for Medicaid through OHS. In addition, the OHS divisions that oversee supplemental programs (e.g., SNAP) send separate information packets to William, Maria, and Linda for the programs for which they were eligible.

Joanna's eligibility and enrollment team receives a call from Maria about how to log into her mother's member portal. The eligibility agent explains to Maria that OHCA manages the portal for Medicaid benefits and transfers them to OHCA.

- 👎 I wish we had a single point of contact for members calling in so we don't have to transfer them between OHCA and OHS
- 👎 I wish we had a way to capture and confirm the accuracy of member contact information
- 👎 I wish I could send all program information in one communication through the communication channel members prefer
- 👎 I wish we had a more efficient way to satisfy federal requirements on mailed communications to members (e.g., custodial children, no permanent address)

OHCA

OHCA sends onboarding materials to newly enrolled members for the MAGI population, which includes information about supplemental Medicaid programs available to members (e.g., SoonerQuit, SoonerRide, Care Management, TEFRA).

A member of the OHCA Care Management team reaches out to those who are eligible for their services for an introductory call.

OHCA Member Call Center
An OHCA Tier 2 call center agent picks up Maria's transferred call from OHS and realizes that she is calling about a login issue. The call center agent re-transfers Maria to the Internet Help Desk because he does not have access to reset passwords.

- 👎 I wish that I did not need to transfer members so much and instead had the information or access needed to support them
- 👎 I wish that we had a more automated system and process for letter creation and mailing
- 👎 I wish it were easier to make edits to letters
- 👎 I wish it were easier to identify the right populations to send letters to

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OHCA FUNCTIONAL TEAMS: Business Enterprises · Member Eligibility & Enrollment

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UTILIZATION OF SERVICES

Use Benefits

MEMBER

Linda looks through the Medicaid provider directory and looks for a PCP nearby who can help her with arthritis. She makes a couple of calls to confirm which clinics are accepting new patients and schedules an appointment for a few weeks out.

Linda attends her appointment, paying the $4 copay since she hasn't hit the monthly cost sharing limit (5% of household income). Linda's doctor determines she needs hand surgery to manage her worsening arthritis, which requires Linda to wait for a prior authorization approval.

During her appointment, Linda raises her concerns about anxiety, but the provider hasn't been trained to connect members with a behavioral health specialist and is unable to help her. When Linda gets home, she searches online for Medicaid providers for behavioral health and is guided to the OHCA provider directory. She eventually finds a behavioral health specialist, but the clinic is quite far and the soonest availability isn't until 2 months later.

While waiting for her surgery to be approved, Linda receives a letter in the mail from OHCA that says her PA has been denied. Alarmed, she reaches out to both her doctor and OHCA to resolve the issue. After much back and forth, Linda does receive approval on a corrected PA and she schedules surgery for her hand.

- 👍 It was easy to find a PCP in the provider directory accepting new Medicaid patients
- 👎 I wish I could see my EOB and manage my health benefits on the member portal
- 👎 The letters I receive about Medicaid are confusing and I often don't even open them
- 👎 I wish it wasn't so hard to get referrals for specialists who can see me within a reasonable time frame
- 👎 I wish OHCA would send me letters written in plain English

ⓘ Linda's interactions for prior authorizations and call center inquiries are currently handled by OHCA but will be handled by CEs for managed care plans in the future

ⓘ If appealing a PA decision, members can file a member complaint or grievance form and call the OHCA member helpline for help

GUARDIAN

Sara meets regularly with Jamie's OHS foster care case worker to discuss Jamie's asthma needs and overall wellbeing. Under the Children's Specialty Program, Sara does not need to pay any copays for Jamie, but she does need consent from the case worker for medical procedures.

- 👎 I wish there was an easier way for me to get consent from OHS case worker for my foster child

CAREGIVER

Maria speaks with her mother's OHCA care manager about her mother's worsening conditions and the care manager helps Maria apply on her mother's behalf to a nursing home that fits her needs.

After Maria takes her mother in for a level of care determination at the nursing home, she receives the news that her mother has been approved for 24/7 care.

TRIBAL

Kaya decides to receive her healthcare at an Indian health facility where she is able to see physicians without referral and is exempt from paying copays for services.

ABD

Every month, William gets a call from his care manager who checks in on how William is doing and reminds him of his upcoming doctors appointments and at-home physical therapy sessions.

At his care manager's guidance, William submits an application for the OHS ADvantage waiver program to lower the cost of his PT sessions and home-delivered meals. He stays on a waitlist for several months before an OHS nurse reaches out to conduct a level of care determination but eventually is approved for the program.

Ahead of an upcoming appointment, William attempts to schedule a ride through OHCA's SoonerRide reservation line but the request is denied because his specialist is too far.

The SoonerRide scheduling agent directs William to OHCA's member helpline, and after 4 call tree options and 2 transfers, he finally reaches an OHCA member services agent. William is told that his ride request will be forwarded to the SoonerRide team who will call back to confirm approval for his unique circumstances. His anxiety increases as his appointment date nears without receiving a call back.

ⓘ Qualified medical escorts (e.g. friends or family who drive members to and from a provider) may receive SoonerRide mileage reimbursement

- 👍 My care manager is so proactive about helping me find providers, sending me options for locations, and scheduling appointments
- 👍 When I have issues with a provider or service (i.e., PA) my care manager sorts it out on my behalf
- 👍 My care manager introduced me to so many programs I didn't know members could receive (e.g., SoonerRide, support for my bills during winter)
- 👍 I love that I can rely on my care manager as my source of truth for any communications or information related to benefits
- 👎 I wish SoonerRide requests were easier to schedule and that I could check the status of my ride without waiting 2 hours on the member helpline
- 👎 Sometimes my SoonerRide doesn't show up, and my provider blames me for being a no-show
- 👎 It would be great if my SoonerRide could also help me run errands (e.g., picking up my prescription, dropping by the grocery store)
- 👎 I wish I knew I could get reimbursed through SoonerRide for mileage
- 👎 I wish providers were more aware of the SoonerRide mileage reimbursement program, which requires a doctor's signature
- 👎 I wish the waitlist for waiver programs wasn't so long

PROVIDER

When Linda arrives, Glenn's staff verify her identity, eligibility, and coverage for services through the OHCA provider portal. His nurse also conducts an SDOH/health screening during patient intake.

During Linda's appointment, one of Glenn's physicians discusses treatment options for Linda's worsening arthritis and requests a PA for hand surgery to help manage her symptoms.

After a day, the physician is notified that Linda's PA is denied so he calls the OHCA provider helpline as he is unable to determine the reason himself on the provider portal. After a long wait, an OHCA call center agent informs him they do not have edit rights and they have to transfer his issue to the PA team via email. They tell him he should hear back within a week.

After waiting a week with no response and some prompting from Linda, he calls OHCA again to find out the current status of the PA. OHCA Provider Services says they will reach out to the PA team on his behalf. Some time later, he finally receives an approval notification for the PA and informs Linda she can schedule her hand surgery.

ⓘ If reception notices a patient is uninsured, they will be counseled on Medicaid and given assistance on enrolling

- 👎 I wish it was easier to be alerted of or search for major policy and rate changes from OHCA (e.g., smart search on the public website)
- 👎 I wish it was easier to understand and resolve prior authorization denial reasons on the provider portal
- 👎 I wish the process of calling into the OHCA provider call center wasn't so cumbersome (e.g., multiple transfers)
- 👎 I wish there was a better network of specialists who accept Medicaid and have availability
- 👎 I wish I had time and incentive to capture additional context on the patient (e.g., related behavioral health challenges, SDoH factors)

LTC

Amy ensures her staff of nurses periodically perform a re-determination of medical eligibility for patients at her LTC facility, based on OHCA-defined frequencies and waiver programs

- 👎 I wish it was easier to hand off patients to other LTC facilities or agencies when they become no longer eligible for 24/7 care

FQHC

- 👎 Given our high level of staff turnover, especially adminstrative staff, there's a lack of continuity when it comes to institutional knowledge across all of our departments

CONTRACTED ENTITY (CE)

Brandon's care management team reaches out to members with complex needs, usually within the first 45-90 days of launch, to transition them from the previous plan.

Conscious of starting off on the right foot with members during this transition, Brandon instructs his team keep all services in place for the first 180 days so that changes to care plans or authorizations are introduced only after care managers have familiarized themselves with members.

Brandon's care managers collect SDOH information as part of the health risk assessment and connect members with CBOs as needed.

- 👍 I really appreciate that my current OHCA care manager facilitated a warm transfer and introduction to my new CE care manager
- 👎 It's frustrating that IT systems within our organization and across the healthcare ecosystem don't talk to each other
- 👎 I wish state agencies would talk to each other - we often get asked by different departments to share the same data
- 👎 There is so much data collected between us and the state, but it's hard to tell what's impactful
- 👎 Wrap-around services that address SDOH needs are usually not reimbursable, and ROI is difficult to demonstrate
- 👎 We've experimented with different private/public partnerships, and they don't always go well (e.g., Uber/Lyft)

COMMUNITY BASED ORG (CBO)

Claire's network of CBOs regularly sees Medicaid members seek help on health-related social challenges.

While Claire and her team try to keep a pulse on utilization of CBO services, it's largely qualitative and not data-driven. Measures of performance differ greatly depending on service type and ability/capacity to track encounter data, which is low among most CBOs.

- 👎 I wish we had the resources to track referrals and outcomes to demonstrate ROI to Medicaid members and other state agency programs
- 👎 I wish there was a simple, user-friendly way for us to collect and share data with OHCA and other partners (e.g.,CEs, providers, other CBOs)

AGENCY

Joanna's colleagues across OHS, OHCA, OJA, and DMHSAS must work closely together to help non-MAGI members navigate their benefits and services across state programs. This includes completion of required benefits administration activities, such as prior authorizations and level of care determinations.

Sara interacts regularly with Jamie's OHS foster care case worker to discuss Jamie's health needs and get consent for services and treatment. The foster care case worker can refer Jamie to additional Medicaid programs, such as OHCA's Specialty Program for At-Risk Kids (SPARK).

Once a space becomes available for William within the ADvantage waiver program, an OHS ADvantage Administration Unit representative contacts him to determine financial eligibility. Once confirmed, an OHS long-term care nurse contacts William to set up an appointment to come to his home and complete a physical assessment to determine medical eligibility.

- 👎 I wish there was a unified, single system for LTC application processing
- 👎 I wish there was a comprehensive approach to waiver policy, decision-making, and operations for long-term care. The current process is confusing for state staff and providers
- 👎 I wish there was more clarification on cross-agency roles and responsibilities and more communication between agencies
- 👎 I wish it was easier for other agencies to understand who they can or can't talk to due to privacy rules (e.g., adoption)

OHCA

OHCA Member Services and Provider Services call centers field calls for current Medicaid members and providers. The most common call reasons are related to status updates/inquiries (for PAs and claims), questions about denial reasons, and SoonerRide.

OHCA Member Call Center
An OHCA Tier 2 call center agent picks up William's transferred call from Tier 1 regarding his SoonerRide denial but is unable to directly make edits or approve his request. The agent gathers William's information and ride details and forwards it to the SoonerRide team through email, and tells William he will hear back shortly. The agent receives multiple callbacks from William and other members stating they have not heard back from the SoonerRide team in a timely manner and are worried they may miss their appointment, but the agent is unable to take additional action.

ⓘ **OHCA Provider Education Team**
When the Provider Services team is unable to resolve an issue, the Provider Education team will help investigate and follow up with a solution. These issues usually come through the dedicated email or are transferred from other departments

- 👎 I feel bad when I have to tell the member to hang up and call another number
- 👎 I wish I didn't receive so many low complexity calls or "incorrect" transfers (e.g., basic policy questions, verifying a physician is enrolled with OHCA)
- 👎 I wish I didn't have to spend so much time explaining confusing communications we send to members and providers
- 👎 I wish members could contact SoonerRide directly
- 👎 I wish I didn't have to manually reconcile behavioral health PAs and claims codes to help providers
- 👎 I wish that we had an electronic pharmacy prior authorization system

SYSTEMS & TOOLS
MMIS Business Objects
MMIS Claims XTen
MMIS CTI
MMIS Data Warehouse
MMIS iCE MMIS
MMIS Initiate
MMIS Letter Generator
MMIS Member Portal
MMIS MEDATS (PA)
MMIS Provider Portal
MMIS PA Workflow (PA)
MMIS Qualitrac
OTHER eQSuite
OTHER Harmony
OTHER IMS
OTHER InterQual (PA)
OTHER MyHealth (HIE)
OTHER PAI
OTHER RightFax

OHCA FUNCTIONAL TEAMS: Member Services · Provider Services · Care/Case Management · Prior Authorization · SoonerSelect · Behavioral Health

Submit Claims

PROVIDER

Glenn's practice uses a 3rd party clearinghouse, which creates and submits a claim for Linda's care through OHCA's provider portal and uploads all necessary documentation.

When Glenn is notified by the clearinghouse that the claim was denied, he checks the provider portal. The denial reason is unclear, so he calls OHCA's provider helpline; it takes 20 minutes before he is able to connect with an agent. The agent tells him that the cause of denial was an incorrectly entered member ID. After resubmitting the claim through the clearinghouse, Glenn receives a notification that the claim has been approved.

ⓘ State-operated providers submit claims to OHCA for services provided and receive inter-agency payments (e.g., general medical, critical access, rehab or psych hospitals operated by OHS or DMH)

- 👍 OHCA processes claims much faster than most state healthcare authorities with whom I interact
- 👍 Most of the claims I submit are auto-adjudicated, with no additional action required, which makes my job easier
- 👎 I wish it was easier to see what the claim denial reason was on the provider portal
- 👎 I wish it was easier to get information on CPT code restrictions and how many times a code has already been used for a member before submitting a claim

CONTRACTED ENTITY (CE)

Brandon's claims department receives and documents incoming claims from providers and verifies the submissions. They review the claims to determine eligibility, coverage, and compliance with contract agreements. As a part of this process, the team manages claim status reporting and follow up with providers where additional clarification is needed.

The claims team determines reimbursement amounts based on contractual agreements and notify both the member and provider on adjudications. Brandon's team sends claims files and required reports to OHCA.

ⓘ For denied claims, providers are notified of denial reasons and steps to appeal

- 👎 It is very challenging for our team to pull claims files and reports out of the system. The reports are often complex, and it requires manual work

AGENCY

Joanna receives claims data from OHCA, which is analyzed by her team to determine billbacks to OHCA for Medicaid services provided by OHS. She also uses this data to better understand their Medicaid population, improve their programs' services and demonstrate ROI.

If members call Joanna's OHS call center team with questions about claims or payments, the agent needs to identify and transfer them to the appropriate OHCA team for support.

- 👎 Because our agencies use different systems, it takes a long time to get the data that I need to determine reimbursement for the Medicaid services provided by OHS

OHCA

OHCA processes and adjudicates claims for the full Medicaid population (MAGI and non-MAGI), and OHCA call center agents field calls related to claims questions, denials, and appeals.

OHCA also shares claims data with other state agencies (e.g., OHS) on chargebacks related to Medicaid services.

- 👎 I wish there was more cross-training across departments on team responsibilities, which would help more issues be transferred correctly
- 👎 I wish that we had a digital tool for managing claim coding, definitions, and restrictions. They are currently manually maintained in physical binders
- 👎 I wish that we had a dedicated claims department to handle claims issues from start to finish

SYSTEMS & TOOLS
MMIS Business Objects
MMIS Claims Processing
MMIS CTI
MMIS Data Warehouse
MMIS iCE MMIS
MMIS Initiate
MMIS Letter Generator
MMIS Provider Portal
OTHER DRG Calculator
OTHER Great Plains
OTHER IMS
OTHER MyHealth (HIE)
OTHER PeopleSoft
OTHER RightFax
OTHER Tableau

OHCA FUNCTIONAL TEAMS: Business Enterprises · Provider · Third Party Liability · Program Integrity · Finance · Behavioral Health

Receive Payment

PROVIDER

Glenn sees payments come in for claims within 14 days of approval. As part of his practice's regular operations, Glenn's team work with their clearinghouse to review invoicing data, manual adjustments, stop payments, voids, and re-issuance to ensure everything is accounted for.

- 👍 OHCA is extremely fast and very consistent with payment timelines

CONTRACTED ENTITY (CE)

Brandon's CE pays the provider for approved claims. On an ongoing basis, the CE conducts quality and utilization management reporting and reviews.

OHCA

OHCA sends payment on approved claims to providers, cutting checks on a weekly basis.

- 👎 I wish that we had a more automated process to share data between MMIS and PeopleSoft for financial reporting and accounting
- 👎 I wish that we had a better process and/or tool to help identify and reconcile wires and checks received with accounts receivable

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OTHER MyHealth (HIE)
OTHER Great Plains
OTHER PeopleSoft

OHCA FUNCTIONAL TEAMS: Finance · Business Enterprises · Legal · Behavioral Health

Process Appeals

MEMBER

If Linda chooses to appeal a payment or denial of service, she can call the OHCA member helpline or file a member complaint or grievance form to eligibility@okhca.org, where the complaint will be forwarded to OHCA's QA department for investigation and further triage.

- 👎 I wish info on filing appeals and grievances was easy to find. The process and information requested is confusing

CAREGIVER

After learning that her mother has experienced several falls during her first month in the nursing home, Maria is concerned her mother is being neglected and asks her OHCA care manager how to file a complaint. Maria is told she needs to email OHS [redacted] as complaints for nursing homes are handled outside of OHCA.

- 👎 I'm never quite sure if I need to be reaching out to OHCA or OHS for my mother's care

PROVIDER

For denied Medicaid managed care claims, Glenn submits a claim appeal and review form, along with documentation, to the relevant CE per their guidelines. After a short review period, he is notified of an appeal decision by the CE.

For denied Medicaid fee-for-service claims, Glenn is not as familiar with the OHCA appeal process, so he calls the OHCA provider helpline. The call center agent helps him submit the appropriate forms and documentation.

- 👎 I wish the various CEs and state agencies we coordinate with had a single, standardized process for appeals
- 👎 I wish I could understand the various appeals processes across the different health plans and state agencies with whom my practice contracts

LTC

Amy complies with the OHS Ombudsman's investigation of Maria's complaint. She ensures that the appropriate actions are taken to address the issues in a timely manner.

CONTRACTED ENTITY (CE)

A different department at Brandon's CE processes appeals submitted by providers on denied claims, including required documentation.

They complete internal reviews on the initial decision to deny coverage. Once the investigation is complete, members are notified of appeal decisions.

- 👎 Each state mandates unique denial data collection and reporting standards, adding complexity to our operations

AGENCY

The OHS Ombudsman notifies Joanna that a complaint was filed against a nursing home serving their non-MAGI Medicaid population. The Ombudsman investigates the complaint, while Joanna verifies that the complaint is addressed in a timely manner and in compliance with federal requirements.

OHCA

For most complaints or appeals, the OHCA QA team investigates all medical complaints and forwards non-medical concerns to the appropriate OHCA or cross-agency teams for resolution (e.g., Program Integrity, Provider Services/Enrollment, Member Services/Eligibility, SoonerRide, OSDH, DME, Legal).

OHCA Care Manager
Maria's mother's OHCA care manager receives a call from Maria with a complaint about her mother's nursing home. Her care manager instructs Maria to contact the OHS Long-term care Ombudsman to file a complaint.

- 👎 I wish there was more coordinated workflow tools and processes to better manage and track complaints/issues within and across agencies

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OTHER PeopleSoft
OTHER RightFax
OTHER Thomson Reuters

OHCA FUNCTIONAL TEAMS: Business Enterprises · Legal · Policy · Prior Authorization

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DISENROLLMENT

Disenrollment

MEMBER

Linda's household income increases, and she reports the change to OHCA. Shortly after, she receives a letter from OHCA stating she no longer qualifies for Medicaid but doesn't understand why she has lost her coverage. The letter suggests she navigate to HealthCare.gov to find new a health plan.

- 👎 The loss of coverage letters look just like any other OHCA letter so I might have thrown mine away; I didn't even know until my doctor told me I was no longer covered
- 👎 The letters don't explain why I lost coverage
- 👎 I wish there were more helpful resources during the transition off of Medicaid other than HealthCare.gov

GUARDIAN

When Jamie turns 18, he is aged out of the foster child program and loses his coverage under the SoonerSelect Children's Specialty plan. Sara helps Jamie research his options for healthcare coverage and walks him through the Medicaid application.

- 👎 I wish there was a way for members aging out of the foster care program to automatically roll over into Medicaid

PROVIDER

A physician in Glenn's practice is retiring. Glenn helps the physician submit a disenrollment form on the OHCA provider portal, including required documentation and signatures. He also makes sure all claims related to the physician are properly submitted by the clearinghouse first and contacts the CEs to inform them of the disenrolled physician.

- 👍 The disenrollment process is pretty straightforward, and I'm given multiple options on how to complete it

CONTRACTED ENTITY (CE)

Brandon and his team connect regularly with OHCA on any changes to member enrollment. Members who are no longer eligible for Medicaid have their accounts at the CE closed, and Brandon's team ensure written notices of the disenrollment are sent to members.

COMMUNITY BASED ORG (CBO)

Claire periodically makes site visits to the different CBOs in her organization's network.

During a visit to one of the food banks, she meets Linda, who is waiting to receive her food parcel for the week, and hears about Linda's experience transitioning off of Medicaid.

- 👎 I wish CEs, OHCA, and other state agencies considered transition planning and collaboration opportunities with CBOs to provide connectivity to ongoing "safety net" services for individuals during disenrollment

AGENCY

OHS case workers coordinate with Joanna's team and OHCA to facilitate disenrollments for members transitioning out of eligibility, such as when Jamie ages out of foster care.

Additionally, Joanna's eligibility and enrollment team redetermines all non-MAGI members by reviewing eligibility annually and sending disenrollment notifications via mail.

On a daily basis, OHS sends OHCA data on member disenrollments to be reflected in the MMIS.

OHCA

OHCA redetermines MAGI members by reviewing eligibility annually. OHCA sends MAGI members notice of disenrollment with resources on available alternatives to receive services.

OHCA processes provider disenrollment forms and updates their MMIS system to reflect the changes.

- 👎 I wish I had more confidence that the people are being disenrolled appropriately

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OHCA FUNCTIONAL TEAMS: Legal · Member Eligibility & Enrollment · Provider Enrollment