From: SURESH, NAGALAKSHMI
To: MCD MCProcurement
Subject: FW: ODM Outreach to Mercy Health
Date: Wednesday, October 30, 2019 9:42:38 PM
Attachments: BSMH Responses to RFI 07302019.docx
image001.png

Nagalakshmi Suresh
Business Analyst, Managed Care Procurement
The Ohio Department of Medicaid
Phone: 614-705-1139
nagalakshmi.suresh@medicaid.ohio.gov

CONFIDENTIAL, PROPRIETARY, AND PRIVILEGED –
MEDICAID PROGRAM PROCUREMENT

From: Allen, Mary <Mary.Allen@das.ohio.gov>
Sent: Tuesday, October 29, 2019 2:21 PM
To: SURESH, NAGALAKSHMI <Nagalakshmi.Suresh@medicaid.ohio.gov>
Subject: FW: ODM Outreach to Mercy Health

Hi Naga,

I am not sure if you received this feedback already, but Jon reached out to me so I am forwarding it on to be included in the database.

Thanks!
Mary

From: Fishpaw, Jon P <JPFishpaw@mercy.com>
Sent: Monday, October 28, 2019 3:29 PM
To: Allen, Mary <Mary.Allen@das.ohio.gov>
Subject: ODM Outreach to Mercy Health

Hi Mary,
I received a note from a colleague of mine in the Youngstown market regrading an upcoming listening session for our Physicians, Practitioners and others to gain more insight around the effects of managed care as ODM works through the managed care procurement process.

Moreover, we provided a system response to ODM's RFI. I have attached this information, and it is our hope that our to and from communication with ODM can be streamlined as part of a single system approach for all of our providers in all of our markets in Ohio.

I hope this make sense.

Thanks for your time and consideration.
Jon

Jon Fishpaw
Chief Government Relations Officer
Bon Secours Mercy Health
c - 513.317.7596
e - jpfishpaw@mercy.com

Ohio Department of Medicaid
Request for Information (RFI)

Ohio Medicaid Managed Care Program
Feedback from Individuals and Providers
June 13, 2019

Section I - Introduction

The Ohio Department of Medicaid (ODM) is planning to conduct a competitive managed care procurement and is interested in hearing from individuals and providers about their experience with the current managed care system and ideas for improving member and provider experience, service quality and system accountability to inform that effort.[1]

Through this Request for Information (RFI), ODM is seeking responses specifically from individuals who are receiving Medicaid services (individuals) and their families, advocates for individuals, providers, provider associations, partner state agencies, and other persons or organizations with relevant information about Ohio's Medicaid managed care program. [2]

Overview of Ohio's Medicaid Managed Care Program

Approximately 90% of persons insured by Ohio Medicaid are enrolled in a managed care plan.[3] ODM contracts with five managed care plans that were selected through a competitive procurement process seven years ago. The managed care plans are responsible for covering all medical benefits (including behavioral health services and prescription drugs) for individuals who are enrolled in the managed care plan. Managed care plans also must provide additional benefits, such as member services and care management.

In addition, other partner state agencies, including the Ohio Department of Aging, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, the Ohio Department of Job and Family Services, and the Ohio Department of Developmental Disabilities, help ODM with administering certain parts of the Medicaid program. Many individuals in the Medicaid program who may be enrolled with a managed care plan also receive services delivered in coordination with one or more of these agencies or their local counterparts.

---

[1] Assistance to interested parties with a disability or Limited English Proficiency (LEP): Individuals with a disability may request accommodation to participate in responding to this RFI. Individuals who speak a non-English language may request language assistance relating to this RFI. Individuals may contact the ODM Consumer Hotline at 800-324-8680 (TTY: Dial 711) to request a reasonable accommodation or language assistance.

[2] Individuals or others who choose to respond to this RFI may be referred to in this document as "interested parties" or "respondents."

[3] Approximately 120,000 clients are enrolled in MyCare Ohio, which is a managed care program designed for Ohioans age 18 and older who are eligible for both Medicaid and Medicare. These clients are enrolled in MyCare Ohio Plans (MCOPs), which coordinate their physical, behavioral, and long-term care services. This RFI is focused on the traditional Medicaid managed care program, not MyCare Ohio. There is no anticipated impact to the MyCare program.

Section II - Request for Information

ODM is asking for your input and suggestions in the following general topic areas:

- *Communication and engagement with individuals:* How easy is it for individuals to access health care and find a provider, and stay engaged in their health care efforts?
- *Grievances and appeals:* There are times an individual or provider may disagree with a decision made by the individual's managed care organization; ODM is seeking first-hand experience and ideas regarding the grievance and appeals process.
- *Provider support:* What administrative processes or functions make it easier or more difficult to do business in a managed care environment? How might sharing data be improved?
- *Benefits and delivery system:* In what ways can the managed care program improve access to services, and what unique arrangements should ODM consider in place of a one-size-fits-all model of managed care?
- *Care coordination and case management:* As ODM focuses on improving outcomes for individuals with complex health needs, how can managed care organizations and partners work to ensure appropriate care coordination and case management?
- *Population health:* How can the managed care program improve health outcomes such as infant mortality, adult smoking, and cardiovascular disease?
- *Performance measurement and management:* How should ODM be measuring the performance of the managed care program and the individual managed care plans regarding both processes and outcomes?
- *General feedback:* At the end of this RFI you have an opportunity to offer your thoughts about anything not addressed specifically in our questions.

Specific questions for each of these general topics are below; refer to the question number with each response you submit. Also, note that while you are encouraged to submit narrative responses to any or all the following questions, **you are not required to respond to every question.** You may choose to respond to only those questions that are of interest to you. [4]

For instructions on how to format and deliver your response, see Section V on the last page of this document.

[4] ***ODM is planning to issue a separate RF/ to collect feedback from current managed care plans and potential applicants for the managed care procurement, and ODM will not review responses to this RF/ from current managed care plans or potential applicants for the managed care procurement.***

Communication and Engagement with Individuals Enrolled in Managed Care Plans

Access to care

1. As an individual enrolled in a managed care plan, how often do you have difficulty obtaining access to services?
    - Less than one time a year
    - Approximately once a year
    - More frequently than once a year
    - More frequently than one time a month

2. What kinds of difficulties do individuals enrolled in managed care plans have in being able to access health care? What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?

    The availability of primary care, OB/Gyn, pediatric providers, and behavioral health in certain areas in Ohio is limited*, making access to care challenging for patients and creating unnecessary ED visits and hospital services.*

    We recommend that Ohio Medicaid ***require managed care plans to provide an outreach program that helps educate individuals when they are approved for Ohio Medicaid and assign them a primary care provider that can help them navigate the system.***

    MCPs must be held ***more accountable for authorizing acute care services and coordinating timely transfers from acute care settings to higher levels of care.*** *The sole responsibility should not be placed on the hospital/provider to coordinate placement and find availability in SNFs, LTCs, rehabilitation facilities, mental health IMDs, hospice services, etc. When coordinated care is not able to be arranged within 24-hours, the managed care payer must be required to reimburse the acute care facility a per diem rate to cover the expense of ongoing care, until transfer is complete.*

Communication

3. How often do you receive communications from your managed care plan regarding your health care needs?
    - Less than one time a year
    - Approximately once a year
    - Monthly
    - Never

4. How do you think communication with individuals enrolled in managed care plans could be improved?

- Please provide any specific feedback for the following groups:
  - Individuals who primarily speak a non-English language
  - Individuals with cognitive or intellectual disabilities
  - Individuals with physical disabilities
  - Individuals who may not understand health care terminology
- How could managed care plans use technology (such as web-based applications and mobile phones) to assist individuals with their health care needs?

- How could managed care plans improve communication with individuals who do not have a mobile phone or computer or do not have reliable internet service?

5. What could ODM and managed care plans do to communicate with individuals enrolled in managed care plans and their families to regularly provide input and feedback?

   *The Ohio Department of Medicaid should **require MCPs to engage in bi-directional communication with members/patients** when promoting health education, healthy lifestyles, and when working with them to coordinate medical care. One-way communications, such as mailed letters or website updates, are not sufficient to ensure member understanding.*

Engagement

6. What are some ways that managed care plans and providers could encourage or assist individuals to be involved in their health care and promote healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?

   *MCPs should **provide incentives** to patients for weight loss, exercise, smoking cessation, and other healthy behaviors. In-person or WebEx educational seminars should be offered to members, as many of them are not informed and do not understand the elements of a healthy lifestyle. Education on disease-specific diets and individualized exercise plans would also be beneficial.*

   MCPs must ensure their members receive colonoscopies, breast exams, prostate exams and other appropriate screenings based on federal age guidelines, which could help reduce the overall costs of treating patients with cancer.

   *MCPs should be **required to run quarterly ED usage reports** and reach out to enrollees who commonly use ED services for non-emergent care to educate them on why it is important to seek care in the appropriate setting (urgent care, PCP office). MCPs should be **required to send out bi-directional, annual primary care reminders** to enrollees to schedule their checkup with their PCP.*

Provider search

7. How could managed care plans make it easier for individuals to search for providers? In particular:
    - What tools and resources would be most helpful (e.g., calling member services, online provider directory, hard copy provider directory, mobile application)?
      All the above resources should be offered. *Additionally, on any hard copy provider directory there should be a disclaimer directing the member to go online for the most up-to-date directory.*
    - Within those resources, what type of information should be provided to help an individual choose a provider?
      The hard copy provider directory should be ***broken down by zip code, then by specialty, etc. All on-line provider directories should be set up so that members can enter their home address and the providers closest to them appear first in the directory by specialty.*** *This approach will assist the state and MCPs in cutting down on transportation costs, as well as the providers in minimizing abandoned appointments due to transportation issues.*

      We recommend ODM require Online MCP directories be updated no less than 2x a month with monetary penalties to the plan for non-compliance. Delays and inaccurate information can cause individuals to have issues accessing care.
    - Are there ways to make these resources more accessible and easier to use?
      Requiring MCPs to make a ***variety of resources*** *available will help their members access the information they need to maintain their health. When a member enrolls with the MCP, their primary delivery preference should be selected so that the plans understand the best way of communicating with that member. MCPs should also be required to maintain an up-to-date provider directory*

Access to information about your health

8. How do individuals get information about health or medical topics (e.g., their doctor, their managed care plan, friends or family, the internet)? What could the state or managed care plans do to help individuals get the information they need to understand their health care condition and treatment options to make health care decisions?

   Accessing information about a patient's ***health should primarily reside with the member's clinical team. Care coordination as well as ongoing follow-up and health education for chronic healthcare needs must be a shared effort*** *between the MCP and the patient's clinical care team.*

Grievances and Appeals

9. How can managed care plans and the state obtain feedback and be accountable for addressing member concerns over time? Is there a proactive approach (as opposed to a complaint-based system) that should be explored?

MCPs should have member relations teams to develop plans and address and resolve member issues. The state should develop a robust system of bi-directional communication with MCP members to ensure they are satisfied with their care management experience and the communication from their MCP.

10. How could managed care plans improve their appeal processes for individuals and providers?

The state should have a standard policy for the appeals process. ODM should require that each MCP report auditable monthly statistics on aging and total volume of appeals backlog to ODM for oversight purposes along with outcome of decisions (i.e. overturn rates).

Given the vulnerable patient population, ODM should mandate that all MCPs allow the patient's clinical care team to file appeals acting on the patient's behalf by presenting the patient's signed general medical consent form for treatment.

Timeframes and processes for retroactive authorizations and appeals should be consistent between plans instead of allowing each plan to determine their own timeframes and processes. Inconsistent timelines and processes add significant administrative time and costs, taking precious resources away from patient care.

*Further, **allowance of external appeals and complaints for providers** (rather than members), should be guaranteed through the program with costs paid by the payor, for **binding adjudication** by ODM or their contractor for technical complaints.*

Preferably, an online complaint form to submit issue tickets for information gathering with required responses for binding final determinations should be utilized for appeal review. The volume of complaints relative to member lives/claims should be used in renegotiations and awards of contracts for the Managed Medicaid program, as payor performance behavior should be captured in the percentage performance.

Currently, in the state of Ohio, external appeals are done member-level, but since the member has no responsibility (regardless of whether the claim is denied or paid), issues persist getting patient support for cases, and independent review organizations will not adjudicate due to the lack of patient responsibility.

Complaints to the state are mostly concerned with getting a response from the payor, whether it is correct or not, and do little to resolve adjudication issues.

11. How could the state and managed care plans use data about appeals to improve utilization management and access to care?

When a hospital/provider consistently reaches an appeal overturn rate of 75% (volume or dollars) for a specific denial reason (medical necessity, authorizations, etc.), the MCP should be required to cease utilization/authorization audit activity for that hospital/provider. Such audit activity is time and resource intensive and should not be required of hospitals that have demonstrated (through a very high appeal overturn rate) that an MCP has improperly denied a substantial proportion of claims.

We recommend that the Ohio Department of Medicaid require MCPs to report monthly the total volume and dollars held in appeals and pre-payment review by aging categories (30-days, 60-days, 90+ days). Performance penalties should be assessed to MCPs with appeal backlogs greater than 30-days. In addition, ODM should analyze the data reported to determine where plans have varying requirements and issues and standardize the latest and best practice for all contracted MCPs.

12. If you have direct experience using the appeal or grievance procedures, can you share information about your experience?

The common and recurring MCP practice of placing holds of payment on large-dollar medical claims to conduct clinical review audits by non-credentialed clinical staff is unacceptable. Many times, MCPs utilize third party auditors, staffed without clinical or coding credentialed auditors, and the staff unjustifiably deny high-dollar medical care and downgrade DRG levels of care, creating significant administrative costs to appeal and overturn appropriately delivered services. The MCP must be required to acknowledge its receipt of clinical authorization conducted prior to and during hospital admissions and honor that authorization to substantiate reimbursement of the claim per agreed rates between the MCP and provider, not subjecting the provider to unjustifiable retroactive audits or claim holds for high-dollar reviews.

We experience inconsistent procedures from one MCP to another is a major issue with appeals and grievances. It is cumbersome, costly and inefficient for providers to track and pursue each of the different appeals processes.

MCPs must be required to publish clear policies regarding the process of obtaining a retroactive review for certification, should a patient present as ineligible for Medicaid coverage at admission. Often patients eventually become eligible, which means the service should be retroactively covered for 90 days. However, MCPs often deny these claims, in violation of their contract with ODM. This lack of clarity also persists in the appeals process, where providers are currently required to appeal for denied days. Providers and MCPs waste administrative resources researching and coordinating these retroactive reviews.

In addition, MCPs must do a better job of complying with state and federal regulations to assure accurate denials. For example, the Newborn and Mother Health Protection Act states that if the notification of the admission for birth is 48 hours or less for vaginal delivery and 72 hours or less for a c-section, benefits cannot be denied. Therefore, hospitals cannot be denied for lack of pre-authorization. Currently, Ohio MCPs deny claims lacking preauthorization of the birth, forcing the provider to incur the cost of appealing (and providing the language of the statute) to have the denial overturned.
Another example of these alarming inconsistencies is patients being admitted through the ED to an acute care medical bed for services related to overdose or self-inflicted injury. In these instances, patients are medically stabilized and discharged to an inpatient psychiatric bed under a psychiatric diagnosis. MCPs do not follow Ohio Administrative Code 5160-2-65(M)(3). These failures to adhere to state and federal regulations slow reimbursement and consume administrative resources for providers and payers, increasing the cost of healthcare.

MCPs (which include any downstream contractors or subcontractors) should be required to follow and adhere to all state and federal regulations and laws when denying claims and/or requesting documentation for audits. If an MCP engages in a pattern of 15 claims or more denied because of a MCP's failure to follow such regulations or laws, the MCP should be required to remit to the affected provider an additional payment above the agreed-upon fee schedule for each claim.

Significant unnecessary administrative costs are incurred by both providers and MCPs in working coordination of benefits (COB) reports (HMS report), where on average 75% of the accounts have been incorrectly identified as having a different primary payer (i.e., a payer other than the MCP). MCPs (again, including any downstream contractors or subcontractors) should be required to maintain accurate COB information and only request from providers confirmation of such information when the plan has completed and confirmed such information. If a pattern is determined where 25% or more of the claims a plan requests providers verify are unnecessary (i.e., the member does not have another payor source)—the request should be considered a non-valid request that has created

an administrative and financial cost to the provider. ODM should implement a process to address the MCPs' failure to accurately maintain COB information.

Provider Support

Standardization across managed care plans

13. Provide suggestions about how ODM could promote greater consistency of prior authorization requirements across managed care plans (e.g., requiring all managed care plans to use the same state-developed prior authorization form, or having the state establish which services can/cannot be prior authorized), including the pros and cons, potential barriers, and ideas for addressing those barriers.

*We strongly recommend that ODM **set universal, state-developed prior authorization forms and lists of services to which prior authorization applies, as well as mandate that requests for prior authorization be made through an online portal.** Egregious authorization requirements are one of the major administrative burdens MCPs place on providers, driving up the cost of care by requiring additional unnecessary authorizations and by delaying services to members and payments to providers for those services. **The department should impose penalties against MCOs for poor performance that leads to delays in care due to authorization delays. We recommend setting a standard KPI by requiring MCPs to review authorization requests and provide a decision within five calendar days for non-emergent services and two calendar days for emergent services**. If the plan does not respond within these guidelines, the service should be automatically authorized. We recommend that ODM do not permit MCOs to expand list of services that require prior authorization without ODM approval.*

*We request that ODM stipulate that **MCPs cannot rescind, retract, or modify authorization AFTER a provider has furnished the service based on a matching prior authorization already issued by the MCP. We recommend penalties be devised and enforced in these scenarios, should they persist in the new system.***

*We request that ODM **set a list of approved standards for inpatient and outpatient criteria to be used by all Medicaid payers (MCG/Milliman or InterQual).***

14. Are there certain other functions or processes (e.g., provider oversight, quality measures, reporting) that should be standardized across managed care plans? If so, please identify:
    - The function and how the function should be standardized

***Timely payment** parameters should be standardized for all MCPs. **An Ohio MCP should not be permitted to set timely claim filing parameters less than 365 days from the date of discharge.** To demonstrate average timely payment compliance, the measurements must take into consideration both volume and average dollars for all claims submitted.*

- *How are **average days to payment** defined and counted?*
  Days counted must begin on the date the claim is billed to the MCP and stop

on the date the MCP pays the provider for the medical services provided to their member. The only carve-out days not to be counted during this timeframe should be the days in which the payer has requested relevant additional information needed to adjudicate the claim. For those days, the count should stop on the day the request is sent to the provider and restart the day the provider sends the requested information back to the plan for review. Pre-payment audits, pre-payment reviews of any kind, and claims reprocessing should all be counted when calculating average days to pay. Provider rebills, corrected claim submissions, & providers requests to the payer to reprocess a claim based on a provider billing error, should all restart the clock on average days to payment.

- *How is a **clean claim** defined?*
  A claim which has no defect, impropriety or incomplete documentation that delays timely payment. An MCP's operational system issues and/or clearinghouse operational issues should not impact clean claim status.
- *How is a **paid claim/invoice** defined?*
  - *A paid claim/invoice will only be considered resolved and paid in full when all lines/services on the claim/invoice have been processed and paid according to the reimbursement outlined in the contract between the provider and the payer.*

*All plans should be required to offer an **electronic, encrypted claims and attachment submission method**. The HIPAA risks associated with mailing medical records multiple times due to loss by the MCP or improper loading by the MCP could be avoided if electronic submissions were available for all plans.*

Ohio Medicaid MCPs continue to be confused by the different requirements that the state publishes in the Ohio Administrative Code, billing guidelines and 3M grouper settings. The MCPs continue to release conflicting policies, payment edits and improper grouping of services that result in improper reimbursement. ODM must focus on clarity when communicating updates and changes to guidelines, groupers, and reimbursement settings, so that the MCPs can be better prepared and more successful in claims processing and provider support.

***The Department of Medicaid/CMS (for Medicare) must remain the sole authority on medical procedures allowed to be performed in an inpatient vs. outpatient setting.** Currently MCPs are denying procedures that appear on Medicare's and Medicaid's inpatient-only list, stating level-of-care issues. However, hospital providers are not able to bill the procedure as outpatient because it is not loaded into the Ohio EAPG grouper as a covered outpatient procedure.*

***Prior authorization policies must include allowances for a family of services,** as stated in Senate Bill 129, to prevent unnecessary retro-authorizations to be completed, creating unnecessary administrative burdens for plans and providers.*

***We recommend that Ohio Medicaid credentialing be handled via a centralized process, whereby completing the credentialing process one time will result in a provider credentialed for the Ohio Medicaid Program and all MCPs**. The current process of having to credential providers for each individual MCP is duplicative, creating costly administrative burden, and plaguing plans and providers with significant delays (often a year or more) in securing provider credentialing and access to care in Ohio communities. After completion of the centralized credentialing process, MCPs should be given 10 business days to load and ready the provider in their systems and online reference materials.*

*The concept of managed care should be one that creates **"real time data sharing"**. Unfortunately, history and experience has proven that sharing data between MCPs and ODM is not an easy or accurate process.*

- *MCPs should utilize ODM's preferred credentialing data that is maintained in the ODM payer credentialing system and should acknowledge and follow the same guidelines for processing and paying claims back to one year from the date of approval.*
- *ODM should be the sole source for COB information for Ohio Medicaid members (coverage start and end dates).*
- *ODM should require standardized/uniform CARC and RARC usage for all Ohio Medicaid payers.*
- *ODM should require all MCPs to provide 24 X 7 case management access—allowing level of care approvals and transfers to happen throughout the week, not just Monday through Friday.*

In the spirit of transparency, we would like to see ODM publish the cost reports submitted by each MCP and make public the profit margin that MCPs earn through managing this vulnerable population on behalf of the state of Ohio.

We recommend that each MCP be required to host a quarterly provider outreach meeting to discuss billing procedures, common denial issues, and pre-authorization issues.

- The pros and cons of standardizing the function
  *By requiring that all payers and providers consistently define and provide the above processes and measures, **ODM can ensure that all members will receive appropriate care, at the appropriate site, at the appropriate time, and with the appropriate reimbursement.***

- The potential barriers to standardizing the function and ideas for addressing them
  *The largest barrier will be to **get all MCPs and providers to agree to one standardized process in each of the above areas that will contribute to the successful delivery and appropriate reimbursement of the services.***

  We would like to volunteer to be a part of a work group to assist ODM with standardizing these workflows, definitions and processes to promote better accountability for the Ohio Medicaid program.

Communication about policy updates

15. Describe your ideas for improving managed care plan communication with network providers about updates and changes to plan policies.
    *We recommend mandating that MCPs must **submit payor policies to ODM for approval to ensure they do not conflict with the state plan and consistently handled across all MCPs to ensure members are receiving appropriate access to care.***

    All policy changes should be posted to ODM website that includes the following :
    - ***A complete list of inpatient hospital policies with effective dates and term dates (if applicable)***
      - *Inpatient coverage guidelines (MCG/Milliman and/or InterQual)*
      - *Inpatient only procedure lists (should coincide with ODM)*

    - *Notification of admission policies*
    - *Medical necessity policies*
    - *Concurrent review policies*
        - *Timeliness and access to required specialty peer-to-peer reviews*
    - *Prior-authorization policy and on-line portal access requirements*
    - *Readmission policies*
    - *Retro-Authorization*
- ***A complete list of outpatient hospital policies***
    - *Outpatient coverage guidelines (MCG/Milliman and/or InterQual)*
    - *Outpatient covered code list (should cover everything ODM covers at a minimum)*
    - *Medical necessity policies*
    - *Prior-authorization policy and online portal to access requirements*
    - *Retro-Authorization*
- ***A complete list of all payer policies released in the last 90 days***
- ***A monthly newsletter to providers*** *(online, email blast, fax, or regular mail):*
    - *Providing an overview of all provider policy changes that have occurred in the last 30-day period.*
    - *Access to care updates for members.*
- ***MCPs should be required to have a hospital representative for all contracted hospital providers.*** *Inquiries to MCPs should be acknowledged within 5 business days and a plan of action provided within 10 business days, followed by updates on the action plan every 10 days until resolved. Any manual resolution process must be completed within 30 days of the related mass-adjustment for all impacted providers.*
- *The process, rules, payment determination and other aspects of the program need to be completely transparent and uniform across all MCPs. We recommend MCPs are prohibited from making arbitrary, one sided administrative or policy changes that unilaterally reduce a providers mutually agreed upon reimbursement rate or fee schedule.*

Support for administrative requirements

16. Describe how managed care plans could help providers navigate the plans' administrative requirements, such as submitting clean claims and resolving billing issues. Have you had any experience with a managed care plan assisting you in these areas? If so, what was most helpful?

    MCPs should be required to maintain an ***online log*** *of all claims/operational issues the payer has currently):*

    - *All issues identified & verified as an open issue*
    - *The current status of the issue (updated every two weeks) and issues should fall off the log 90 days after resolution.*
    - *Any provider action that should be taken or not taken, such as:*

- *Claims work-around directives (if available)*
- *Instructions for a provider to hold claims*
- *Information that the payer will automatically adjust claims when the issue is corrected, and no further provider action is needed.*

*We request that ODM require that MCPs have a provider representative that provides **bi-directional communication and follow-up within 24-hours regarding emergent issues and three business days on non-emergent issues** and require service level agreements (SLAs) to measure customer service effectiveness such as call hold times and call abandonment rate.*

*We request that ODM require all Ohio MCPs **to offer monthly operational meetings/calls with all contracted health systems/hospitals.***

*We request that ODM manage **a billing guidance and policy email address where hospitals can submit inquires and receive guidance from ODM that MCPs have to follow.***

We request limiting a managed care plan ability to administratively burden providers with unreasonable requests for medical records or other support would be a value to both parties.

Data sharing

17. How could data sharing between the state, managed care plans and providers be improved? In particular:
    - What data do providers want access to that they do not have access to today; how would providers use that data?

      Providers request to be notified when a patient is readmitted to another facility and the name of that facility. *Medicare currently provides this data, but Ohio Medicaid does not.*

      The system would analyze the data to determine where improvements in care could be made. Cost and utilization data could be reviewed to target individuals that may need interventions.

    - What is the most effective way of providing data to providers?

      The most effective way for MCPs to share data with providers is through third party interfaces that host Community Health Records (CHR). *The CHR provides a community view of data for a patient – including visit summaries, treatment history, lab results, transcription reports, discharge summaries, problem lists, allergies, radiology and other transcribed reports. Hospitals, physicians and other clinicians submit data to the CHR for each patient encounter and other providers can then access this information through the CHR.*

      The CHR also allows providers to check the latest patient demographic and insurance information captured by other providers. Ohio has two CHRs that are already working with providers across the state - CliniSync and HealthBridge. These CHR functions can be fully integrated into the hospital EHR or can be accessed as a web-based application. Since providers across Ohio are already using CHRs for care coordination and continuity of care with other providers, it would be an easy transition for MCPs to also share data with the CHR. Including the managed care data in the CHR would provide a more

comprehensive record for each patient and improve care coordination efforts.

- Are there barriers to providing the requested data; how could those barriers be overcome?
  The main barrier to data sharing among providers and MCPs is the lack of a standard interoperability format for sharing data. *Hundreds of data products are in use across the country, each with different clinical terminologies, technical specifications, and functional capabilities. These differences make it difficult to create one standard interoperability format for sharing data. In fact, not even systems built on the same platform are necessarily interoperable because they are often highly customized to an organization's unique workflow and preferences. Use of a CHR (as mentioned above) is a preferred method of data sharing because it provides an alternative to integration. The CHR can be used by both providers and plans as a web-based application if integration into their systems is not feasible.*

  State privacy laws and 42 CFR Part 2 continue to be barriers because they are more stringent than HIPAA and do not allow as many exceptions to permit information sharing for population management and care coordination with health plans.
  - *Having a more restrictive state law poses a significant barrier to sharing certain types of health information among providers and other entities involved in the continuum of care. If the Ohio physician-patient privilege were aligned with HIPAA and included the same exceptions, hospitals would be able to share patient information more easily and for more purposes than they can today.*
  - *The restrictions in 42 CFR Part 2 for alcohol and drug abuse program records continue to be a major issue that prevents effective care coordination and population health management, specifically for alcohol and drug addicted patients. Part 2 does not allow data sharing with health plans for care coordination without patient authorization. Full alignment of the Part 2 regulation with HIPAA would eliminate the existing barriers to the sharing of patient information essential for care coordination.*

- How could data be shared and used by providers that have limited resources and technology?
  This is not typically an issue for hospitals in Ohio.

18. Describe how managed care plans could support primary care providers in integrating care for individuals enrolled with them. In particular:
    - What kind of primary care infrastructure may be needed?
    - What kind of training or coaching may be needed?
    - How could the state/managed care plans incentivize primary care providers to improve access to care?
    - What kind of primary care models should be encouraged by the state/managed care plan?

Workforce development

19. How could the state/managed care plans support workforce development for different types of providers, including dentists, pediatric psychiatrists, primary care providers, in-home providers and licensed or unlicensed behavioral health providers?

ODM could sponsor an incentive to providers in shortage areas, much like Medicare's Healthcare Professional Shortage Area Program. We recommend that the Department require MCPs to provide quarterly education to providers through bulletins, WebEx, in-person meetings.

Payment innovation

20. What are some ways the state/managed care plans could prepare and assist providers to move through the continuum of shared accountability models that reward providers for quality and improved health care outcomes? In particular:
    - How could the state or managed care plans support and increase the establishment of comprehensive primary care practices and/or accountable care organizations?
      MCPs must be held financially accountable for failing to achieve certain quality metrics (HEDIS as a standard).

      ODM and MCPs must be required to provide detailed attribution reports to providers (by NPI/Medicaid Provider ID) and details on healthcare follow-up.
      ODM should explore PMPM reimbursement to providers who provide care coordination through an ACO or other delivery model.

    - Are there other payment innovations that the state should consider incorporating into the Medicaid managed care program?
      ODM, MCPs and Ohio hospitals continue to struggle with the functionality, inconsistency, and limited abilities of 3M's EAPG Grouper.
      Despite continual follow-up and inquiries to 3M, all users have yet to get satisfactory answers or resolution to many of our questions regarding 3M's inconsistencies (i.e. national vs. state assigned relative weight issues, discounting/consolidation/packaging functionality) with the EAPG grouper.
      We recommend that ODM explore other avenues to reimburse outpatient claims (i.e. Medicare APCs) if 3M is unsuccessful in addressing and correcting the outstanding issues through the updated EAPG 3.14 version of the grouper in 2020.

      We recommend that ODM consider offering a well-rounded, well-funded value-based opportunity that includes care coordination payments, pay for performance dollars (with a reasonable number of measures with attainable targets), and shared savings. Such models should account for social determinants of health, as doing so would decrease PMPM spend and improve patient health and satisfaction.

      We encourage ODM and MCPs to incentive MCPs to work with providers to use alternative payment models to reduce the cost of care.

Other

21. What other suggestions do you have for ways the state/managed care plans could better support providers?

We strongly encourage ODM to explore alternative levels of ASAM equivalent criteria to assist payers and providers in furnishing treatment to SUD patients who currently 'fall through the cracks' when seeking care for addiction and detoxification services.

MCPs need to better gatekeep transportation vendors that are utilized to transport patients to scheduled appointments. Currently the rate of no-shows to medical appointments for Medicaid patients is high due to transportation service providers not showing up to transport members to the appointments.

MCPs need to help connect members to social services and other benefits available to address social determinants of health.

Benefits and Delivery System

Value-added services

22. Managed care plans can provide services not included in the managed care benefit package as "value-added" or "extra" services, such as dental or vision services for adults. What "extra" services do you think are the most valuable to individuals enrolled in managed care plans and why?

Delivery system model

23. The state is considering a managed care model that could uniquely administer services for a particular population (e.g., children and youth in foster care, individuals with behavioral health needs), benefit (e.g., behavioral health) or function (e.g., claims payment) from the existing managed care plan structure. Is this a good idea? For which populations, benefits or functions? Based upon your experience, what are some of the potential pros and cons of this approach?

Access to pharmacy benefits

24. One area that has resulted in national attention and is of significant concern is the administration of pharmacy benefits.
    - What problems have individuals enrolled in managed care plans had with accessing pharmacy benefits? Has that included, for example, challenges with getting certain kinds of medications?
    - What challenges have providers encountered with prescribing and getting approval for certain kinds of medications?

Overall, patients can access in-network pharmacies more readily in the urban areas but have more difficulties in rural areas. Under-payment for prescription services by the PBMs to the smaller

pharmacies located in the rural areas is causing many of these pharmacies to refuse to contract with the PBM or causing them to close. Providers have a difficult time knowing which drug products to order based on different formularies, but acquiring a prior authorization is consistent with most commercial insurances.

Pharmacy benefit managers

25. What are your suggestions for ways the state/managed care plans could improve the transparency, efficiency, and accountability of pharmacy benefit managers?

The best practice would be to ensure that spread pricing is not occurring. PBMs should be paying a fair dispensing fee to the pharmacies in exchange for more patient consultation and education.

26. The state understands that coordination and integration of service delivery improves the experience and overall health of individuals enrolled in managed care plans yet providing well-coordinated and holistic health care can be challenging to individuals and providers alike. Discuss any suggestions you have for improving the integration of services, particularly the delivery of behavioral health and physical health care. Include your ideas about:
    - Improving communication and consultation across providers
    - Shared assessment and service planning
    - Data and information exchanges

27. How can managed care plans provide better access to evidence-based behavioral health practices, such as medication assisted treatment for opioid use disorder, multi-systemic therapy, supportive housing, and supported employment?

    Ohio hospitals are regularly collaborating to develop innovative and comprehensive solutions to address the behavioral health crises in their communities. MCPs should be directed to support these ground-breaking and creative efforts by contributing resources and covering claims for behavioral health services provided by these novel partnerships.

Care Coordination/Care Management

Care coordination/care management

28. Individuals enrolled in managed care plans with chronic or complex health conditions may have multiple agencies involved in the management and coordination of their care, such as the managed care plan, the primary care provider, a behavioral health provider, or another state agency.
    - What are ways the state/managed care plans could improve the management and coordination of care for individuals with chronic or complex health conditions?

- Who would be in the best position to help individuals with chronic or complex health conditions manage and coordinate their care:
    - Their managed care plan
    - Their primary care provider
    - A provider other than the primary care provider
    - Other *(please identify)*

Peer-to-peer rules and processes should be standardized among all MCPs and agencies. *Medical directors from MCPs should be required to be available within 24 hours to perform peer-to-peer reviews. Currently, there are barriers to accessing medical directors, which delay care, transfers to higher levels of care, and discharges.*

We recommend ODM set requirements within the Managed Care Agreements outlining ***the maximum length of time (48 hours) MCPs are permitted to provide precertification to a provider for placement into a higher level of care (SNF/LTAC/Rehab, Nursing Homes).*** *Also,* ***the criteria for qualifying a patient to a higher level of care must be clearly outlined and published on the MCP's online portal.***

We recommend ODM consider a requirement to have the ***MCPs assign a navigator to members to assist them in coordinating chronic care.***

29. What expectations should the state have for managed care plans in performing care management activities to help individuals enrolled in managed care plans and providers manage chronic and complex health conditions? Consider the following in your response:
    - Provider reimbursement strategies when the provider has a role in care management
    - Managed care plan surveillance of data (e.g., admission/discharge, utilization of crisis services) and sharing information with providers
    - Whether there should there be higher expectations for certain populations (if so, which ones and why)

Care coordination needs to be led by MCPs, but with a solid underlying partnership between MCPs and their members' clinical care teams. Measures to evaluate the effectiveness of MCP care coordination must be developed by ODM, and they must be concrete, objective, and measurable. Sharing reports/information with an HIE and other organizations allow providers to understand where patients are seeking care so they can formulate plans of action to improve and/or change processes, as necessary. Joint care coordination time furnished in unison between MCPs and providers should be reimbursed to all parties involved in the care coordination (follow-up coordination, therapy, pain management & CHF clinics, etc.).

Targeting cohorts of MCP members with certain conditions allows resources to be focused, especially benefitting providers who often have limited resources for care management. However, cohorts with similar conditions can still vary by demographics. For example, diabetics in urban areas have different challenges than those in rural settings, so targeted care coordination models must take into account

these variables in order to be successful.

Special populations

30. Are there barriers to the delivery and coordination of care for any of the populations listed below; if so, provide suggestions on how to improve the coordination and communication among providers and systems to prevent gaps in care or duplication of services.
    - Children in foster care
    - Multi-system youth
    - Veterans
    - People with disabilities
    - Justice-involved individuals
    - Other individuals whose needs present special or unique considerations in a managed care system

    MCPs should be encouraged to expand health care and enrollment services (i.e. libraries, shelters, schools, community clinics, YMCAs) in communities by utilizing mobile resources to provide immunizations, preventative care, mammograms, etc. In addition, justice-involved individuals are a significant problem. For example, sex offenders in need of health care services are very hard to place with either home health or skilled nursing facilities. As part of care management, MCPs should be expected to lead the placement efforts.

Cross-system collaboration

31. How could coordination of services/programs managed by partner state agencies be improved? Include your recommendations for the role of the state agency, state agency case manager, managed care plan, provider, and individual enrolled in a managed care plan.
    We would like to see ODM create a statewide behavioral health bed board system that will assist providers and MCPs in placing patients in inpatient care settings and authorizing services timely.

Population Health Considerations

32. What population health measures (e.g., infant mortality, smoking, cardiovascular disease) could the state target in its procurement to have the greatest impact?
    - ***Obesity*** *(not limited to childhood) is an issue that is a precursor to several chronic health conditions in specific populations. Chronic health conditions include, but are not limited to diabetes, hypertension, hyperlipidemia, coronary artery disease and congestive heart failure; all of which lead to hospital readmissions and increased mortality.*
    - ***Tobacco use*** *and smoking is another population health issue plaguing Ohio which leads to heart disease, chronic obstructive pulmonary disease (COPD) and cancer. These conditions are all leading causes of death in Ohio.*
    - ***Maternal and infant health*** *are major issues for Ohio, including the racial disparities that are seen in both. Focusing on comprehensive and coordinated prenatal, postpartum, and interconception care will lead to improvements in outcomes for Ohio's mothers and babies.*

- ***Childhood immunization programs*** *would have a major impact on covered lives long-term, preventing health care complications as children grow older.*
- ***Opioid abuse*** *has been on ongoing issues and requires prevention programs and increased access to treatment programs.*

33. Which entity or entities (e.g., managed care plan, primary care provider, other providers) are best suited to work on improving performance on population health measures? Does it vary by measure?
    - ***Obesity*** *- We need a coordinated and appropriately funded approach between providers, MCPs and government. (e.g. primary care, cardiac and pulmonary rehabilitation, health plan case managers and plan incentives, schools, local programs to promote and support healthy behaviors)*
    - ***Tobacco use*** *- We need a coordinated and appropriately funded approach between providers, MCPs and government. For primary care and MCPs, we need to cover the most effective forms of smoking cessation. For government, state policies that discourage tobacco use in all forms and continued focus in schools for prevention.*
    - ***Maternal and infant mortality*** *– OB/Gyn and Pediatric providers, MCPs, home care for conducting postpartum visits, community organizations (such as CelebrateOne or Cradle Cincy), hospitals, FQHCs, WIC, and local health departments.*
    - ***Childhood immunization programs –*** *Entities involved must work together on improving performance. A coordinated engagement would reap the most improvement.*

Performance Measurement and Management

Provide your ideas about what measures should be used to evaluate the Medicaid managed care program and/or individual managed care plans. In particular:

34. What are the most important indicators of system/managed care plan performance?

    Billing/Claims/Denials/Payment indicators:

    Utilization of an MCP Scorecard that each payer would be required to report each month to ODM. The following statistics should be provided on the monthly scorecard that would be published on ODM's website:
    1. *Number of claims, including total dollars pending in payer system by age (30, 60, 90, 120+ days)*
    2. *Number of claims and total dollars paid within 30 days*
    3. *Number of clean claims denied by reason code*
    4. *Clean claims initially denied and under appeal by dollar and age*
    5. *Corrected/Reprocessed claims, due to payer system error, holding by age and total dollar amount*
    6. *Claims denied for precertification/authorization with root cause for denial*
    7. *Turnaround times for precertification*

    Other metrics to consider would include those that measure impact on the total cost of care.

35. What measures (current or proposed) have the highest value for measuring system/managed

care plan performance? Identify the measures and why they are valuable.

- *Medical loss ratio*
- *Quality/clinical outcomes metrics*
- *Emergency department utilization rates*
- *Urgent care utilization rates*
- *Infant mortality*
- *SDOH data for social determinants*
- *Profit margin specific to managed population*
- *Network sufficiency*

36. What measures have the least value? Identify the measures and why they have limited value.

37. What recommendations do you have for measures that go beyond process to measure outcomes?

General Feedback

38. If you could change one thing about the current Medicaid managed care program, what would it be?

There are too many MCPs with different payor policies to follow. We recommend ODM reduce the number of contractors to limit the variability across plans.

39. What additional suggestions do you have for the state to improve the Medicaid managed care program?

Section 111-Timeline Information

This RFI will be posted to the Ohio Department of Medicaid website on June 13, 2019. Responses submitted in accordance with Section V of this RFI will be accepted through July 31, 2019.

Section IV - Trade Secrets Prohibition; Public Information Disclaimer

Interested parties are prohibited from including any trade secret information, as defined in the Ohio Revised Code (ORC) § 1333.61, in their submissions in response to any RFI. ODM shall consider all responses voluntarily submitted to be free of trade secrets, and such responses if opened by ODM will, in their entirety, be made a part of the public record, and shall become the property of ODM, pursuant to ORC § 149.43. Ohio law provides that information regarding recipients of Medicaid services should not be disclosed for any purpose not directly connected with the administration of programs administered by ODM. Accordingly, any information that would serve to identify an applicant for or recipient of Medicaid services will be withheld from public release.

This RFI is issued solely for information and planning purposes and does not constitute a solicitation. Respondents should note that no contract will be awarded pursuant to this RFI and that responding to, or not responding to, this RFI will neither increase nor decrease any respondent's chance of being awarded a contract from a subsequent solicitation by ODM. As noted above, ODM will not review responses from current managed care plans or potential applicants for the managed care procurement.

The State of Ohio is not liable for any costs incurred by an Interested Party in responding to this RFI.

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.]

Section V- How to Submit Your Response

ODM requests responses to be submitted in electronic format and e-mailed to MCProcurement@medicaid.ohio.gov. ODM requests that all narrative responses submitted in electronic format be provided to ODM in an unprotected (i.e., no password) PDF or as a Word document. However, ODM will also accept paper responses submitted via postal mail to the following address:

Ohio Department of Medicaid
Office of Contracts and Procurement
Managed Care Procurement RFI
PO Box 182709
Columbus, Ohio 43218-2709
ATTN: RFP/RLB Unit

If the response is submitted via e-mail, the respondent will receive an automatically generated confirmation e-mail from ODM upon receipt. If the response is submitted by postal mail and includes an e-mail address, ODM will send a confirmation e-mail within a reasonable timeframe of receipt. No confirmation of the receipt of mailed submissions can be provided if the response does not include an e-mail address.

If the response is submitted via email, convert the response into one single, unprotected PDF document attached to the email. If the submission's size necessitates more than the two PDF documents to contain the entire response, use the fewest separate PDF documents possible. Alternatively, you may submit your response as a Word document.

All submissions (whether paper or electronic) must be received by ODM by July 31, 2019, to allow enough time for consideration as ODM develops the managed care procurement. Materials received after the deadline will not be added to any previously received submissions. Submissions must contain the respondent's name or the name of a representative of the respondent, the organization's name (if applicable), the RFI title and number, and the submission date. Paper submissions must include an email address if the respondent would like an e-mail confirming receipt. The submission, whether paper or electronic, may be used by ODM for internal discussions, discussions with stakeholders, archiving and public records requests. See Section IV for information that is exempt from public record

disclosure.

ODM will accept submissions at any time prior to the posted submission deadline in Section III. ODM cannot guarantee it will consider submissions incorrectly addressed or sent to any email other than the address specified above.

Thank you for your efforts to provide ODM with your suggestions, comments, and relevant information to assist with this project.