From: Cangelosi, Elisha R
To: MCD MCProcurement
Subject: Managed Care Procurement RFI Submission - FCCS
Date: Monday, July 29, 2019 10:53:32 AM
Attachments: Managed Care Procurement RFI Submission - FCCS.pdf

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Hello:

Please find attached Franklin County Children Services' response to the Managed Care Procurement RFI.

Respondent's Name: Elisha R. Cangelosi, MSW, LISW-S, Clinical Director
Organization's Name: Franklin County Children Services
RFI Title (No Number Found on PDF RFI Document Issued by ODM): Managed Care Procurement RFI
Submission Date: 7/29/19

Thank you,
Elisha

Elisha R. Cangelosi, MSW, LISW-S
Clinical Director – Provider Services Department
Provider Management, Community Referral/Coordination and Medical Units
Franklin County Children Services
855 W. Mound Street
Columbus, Ohio 43223
(p) 614-272-4871 (f) 614-275-2755

Respondent's Name: Elisha R. Cangelosi, MSW, LISW-S, Clinical Director

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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

We experience this on behalf of our children in custody more frequently than one time a month. We typically find that plans do not have an understanding of BH services, and therefore, unless we facilitate access for those youth, or provide the Managed Care Plan (MCP) with the options that are available, they do not understand how to obtain needed services. This includes placement services. Also, we have had the most appeals, denials and State hearings around home health hours for our most medically complex youth.

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?

Access to care is impacted by the MCPs understanding (or lack thereof) of our incredibly complex population of children. Without a strong understanding, they become a hindrance to our process, and therefore can become a barrier to children in custody obtaining care.

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

Though due to our volume of children in custody we hear from all plans frequently, communication varies widely from plan to plan. Some plans are more responsive than others, and more responsive at different times. Communication lacks consistency, and paperwork/denials/appeals/etc. sometimes arrive late, or not at all, impacting care for our youth. Communication with plans that have Partners for Kids (PFK) as their care coordination delegate has gone far more smoothly than direct communication with the MCPs. They have worked with us to better understand our system, already had some understanding of our children, and understand the impact of trauma on development. PFK has worked hard to improve timeliness of response, and has built a model with us

that has worked well to address most challenges. Without their involvement, there would be grave concern regarding interactions with the MCPs. We would like to see PFK improve their understanding of BH services and needs, specifically related to placement, as well as both community and placement BH services across the state. Without PFK, the MCPs responses can be less than predictable, slow, and not consistent. There have been times where we have had to send MCPs their own denials to them after receiving them, they have lagged in response time, and generally continue to have a poor understanding of our youth in custody's needs. Often times, despite assigned points of contact, we continue to have to make multiple calls to get the correct individual, and then information is fragmented. There is a general lack of understanding of the urgency of our population, and our timelines. This needs to significantly improve. Otherwise, it becomes an additional barrier for the PCSA to overcome.

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

Communication not only needs to be explained carefully for individuals with the above characteristics, but also for the child welfare staff who are interfacing with the MCPs. Just as MCPs are not familiar with much of our work in the child welfare arena, child welfare workers are not experts at Medicaid Managed Care.

- How could managed care plans use technology (such as web-based applications and mobile phones) to assist individuals with their health care needs?

N/A

- 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?

N/A

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?

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We would like to see an increased understanding of our system. Also, improvement to communication pathways and standardized feedback for child welfare systems. It is very difficult to interpret five different ways of communication and practices from the MCPs.

In addition, when there are changes to medication/treatment, if not already being done, a call to the caregiver to assess how the changes are going, any concerns, etc. would be helpful. This could then be shared back through the point of contact (POC) between systems for any follow up that is needed with the caseworker, etc.

Engagement

4. 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?

N/A

Provider search

5. 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)?
• Within those resources, what type of information should be provided to help an individual choose a provider?
• Are there ways to make these resources more accessible and easier to use?

Child welfare systems would appreciate up to date information on the network of medical and BH providers available. To do this, as stated previously, it will require the MCPs to have a strong understanding of resources and the needs that go along with them. We had one instance of a call with a MCP who provided a scared, anxious foster parent dealing with a young child a resource that had been boarded up and closed down for over 2 years. She drove to that facility to obtain help, only to have to start over again with the MCP.

Access to information about your health

6. 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?

N/A

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Grievances and Appeals

7. 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?

It is recommended that the State/MCPs survey not only individual recipients of benefits, but also the systems that are involved in Medicaid Managed Care (MMC). For example, MCPs or the State could survey PCSAs on a regular basis as to their satisfaction with the MCPs. Performance could be published the same way as the star rating system. Could there be an electronic feedback system that individuals and providers (both medical and contracted placement providers/service providers) could access following interactions with the MCPs? In other words, proactive solicitation of information rather than waiting for something bad to occur (i.e. complaints you reference in the question).

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

MCPs sometimes have great disconnect in their knowledge of whether something is up for appeal. Child welfare will sometimes have to make several calls before we can get everyone on the same page (or wait for the Point of Contact to call us back after making numerous calls, which takes time we often do not have). MCPs and PFK are disconnected on when an appeal occurs. We must alert PFK (MCP does not). This also takes extra time and manpower on the child welfare side.

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

You could use data about what is being appealed to establish trends and patterns, and to explore services that are routinely being denied and causing appeals to see if there should be different standards.

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

Every MCP handles their appeals differently, so it becomes necessary for our child welfare staff to be able to navigate those different systems. We have had situations where the letters have never arrived or have arrived late, and we have missed our window for appeal. As stated previously, we have had the most appeals around home health hours, but have also experienced appeals related to residential treatment stays (specifically SUD residential for youth).

Provider Support

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Standardization across managed care plans

10. 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.

Yes, any standardization would be helpful in this area. As a PCSA, we have to keep track of how each MCP handles their requirements, their paperwork, etc. As child welfare is different than the traditional parent/child relationship, we require different processes. MCPs should be sensitive to the unique needs of custodial agencies and direct impact on child health and well-being.

11. 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
    - The pros and cons of standardizing the function
    - The potential barriers to standardizing the function and ideas for addressing them

The more standardized the MCPs can become, as stated above, the less the administrative burden to the child welfare system. For example, not every MCP accepts our managed care arm forms. Therefore, we have to process paperwork differently for that MCP. As stated earlier, appeal/denial processes vary by MCP, so we have to ensure we understand the way each MCP works. No cons are identified, and barriers would likely be due to the internal "workflow" of each MCP. We have found that to be the case with each plan.

Communication about policy updates

12. Describe your ideas for improving managed care plan communication with network providers about updates and changes to plan policies.

We asked prior to the go-live of MMC that MCPs build their network and work to ensure our youth's providers were covered. Though most were, we still find gaps in their networks. There are still issues from time to time with individual agreements. It would be helpful to have MCPs have similar networks, and for us not to have to change a youth's plan just to get him or her the services he or she needs. Also, we would appreciate the opportunity to provide feedback on policies that impact our work. Standardization around consents, or the elimination of consents and utilization of SACWIS data, would also be preferred (as addressed in #15).

Support for administrative requirements

13. 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?

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As a PCSA, we have not. However, we have heard from providers that they are struggling to submit claims and have them paid in a timely fashion. They have reported to us that they could use technical assistance and training in this area.

Data sharing

15. 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?
- What is the most effective way of providing data to providers?
- Are there barriers to providing the requested data; how could those barriers be overcome?
- How could data be shared and used by providers that have limited resources and technology?

Though not a provider, PCSAs have been requesting practical, useful access to data since the inception of MMC. We would like to be able to view our children's claims and use of services through one access point (instead of logging on by plan by child). This data would allow us to be sure that mandatory (physical, dental, vision) care has been provided and that we always have access to current medications our youth may be prescribed and taking. In addition, we could potentially monitor any medication interactions and potential symptoms. This will be especially important if we continue to have federal medication review audits (Office of the Inspector General Audit completed in 2019 on over 40+ counties in Ohio and additional States across the Nation). It was clear that there was an expectation that we monitor the medications for all youth in custody. They had access to our claims data, but we did not, placing us at a significant disadvantage during the audit process, as well as the obvious impact of not having access to our children in custody's information though we are the custodian.

Also, there is data we are providing to the MCPs that is already available in SACWIS. This is an administrative burden for PCSA's. We have asked that the MCPs be provided with a modified view in SACWIS -or- to be able to receive a report straight from SACWIS as to which children are in custody, custody is terminated, etc. (essentially the 834 without also requiring multiple consents to be signed for each youth for every change in status).

Finally – just a placeholder – what are the plans re: CCWIS related to the Family First requirement, and how does that intersect with MMC.

Supporting primary care providers

16. 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?

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• 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?

N/A

Workforce development
17. 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?
As there are already significant issues with workforce with BH providers, it is critical that the state/MCPs not create additional barriers that make it even less enticing to work in the field (i.e. unnecessary paperwork, mandates, or "hoops" that agencies/workers must jump through which then only delay or impede the necessary care for children and families). Also, it would be incredibly beneficial if the MCPs could somehow partner with providers and utilize their resources to assist BH providers in recruiting/training/teaching new staff.

Payment innovation
18. 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?
• Are there other payment innovations that the state should consider incorporating into the Medicaid managed care program?

As stated earlier, linking satisfaction survey data (specifically for PCSAs and other involved parties) to incentives for the MCPs.

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

To the PCSA, BH providers are often indicating that this was rolled out with very little assistance around billing, maximizing incoming dollars, etc. They report that they do not understand the changes, how to maximize services, and prove medical necessity. There is an immense need for training and technical assistance in this area that only the State (ideally) and the MCPs can provide.

Benefits and Delivery System
Value-added services

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20. 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?

Our children in custody (and at risk of coming into custody) have incredibly complex needs. This includes a myriad of medical issues and/or BH needs. We need to see increased efforts towards parity between BH and medical. In order to do this, the MCPs need to better understand the way trauma impacts our children and families, and what services are best equipped to handle these needs. These services are best delivered as preventative whenever possible, and when not possible, as quickly and as intensively as possible to mitigate further decline and deeper entry into the system. Any technology solutions in this area could be potentially helpful for our youth and families (apps, text solutions) related to BH and other high-need areas.

Delivery system model

21. 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?

Yes, we would be in support of this specialized model for our children and families. As the custodial relationship is not a 1:1 relationship as a parent and child, but rather a system and child, it presents unique challenges. Regarding the population, it would be beneficial for all children involved with a PCSA due to the complexity of their needs. Even just a removal from their parents is a traumatic event and requires a different lens with which you need to view decision making for that child. Their medical needs may or may not have been met to the point of PCSA involvement. The challenges abound. In addition, when specializing, it allows for a common language and understanding to be developed between system partners.

All of that being said, there are many historical examples of good and bad BH carve outs. With Family First requiring evidence based or evidence informed services, we would be interested in how the MCPs and the State will fit together in this process. If MCPs or the State had a knowledge or understanding of services available in other States that we could bring here, that would also be helpful.

Access to pharmacy benefits

22. 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?

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• What challenges have providers encountered with prescribing and getting approval for certain kinds of medications?

There have been numerous challenges around pharmacy benefits, though they ebb and flow. MCPs and PFK have been helpful in obtaining medications for children coming into custody when they come with no meds, etc., or when they are discharging and there are med issues. However, we continue to receive denials in batches at times for certain medications. Step therapy also continues to be an issue at times, as well as controlled substances. We also experience issues with some pharmacies not being covered by certain MCPs (i.e. CVS with United Healthcare). Finally, due to denials, PCSAs are often receiving calls from foster parents and placement providers asking for the child's plan to be changed. Situations where a family may have private insurance are also difficult to coordinate with the MCPs, and have resulted in erroneous denials.

Pharmacy benefit managers

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

We need the MCPs and PFK to understand our children so that they can effectively advocate with the pharmacy around what our child needs in that moment (in crisis situations), and also long term/ongoing. Also, their increased understanding would also assist us in the federal requirement of medication monitoring for our youth.

Integration of behavioral health and physical health services

24. 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

Currently, as stated previously, there is not strong coordination or integration around BH and medical needs. Medical continues to be best understood, and best coordinated, while BH care and services are severely lacking. We would like the State and the MCPs to join in supporting PCSAs and other system partners in better understanding BH needs, and also, advocating for parity in benefits. Though data exchange, communication, etc. are part of a well-functioning system, we are not there as a community (especially when considering the MCPs). Basic understanding must precede more advanced pieces of the coordination/integration puzzle. And BH and medical providers must also be educated on and provided learning opportunities on how the MCPs and the State are there as a support to understanding these needs.

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Regarding shared assessment and service planning, the array of tools and documents is as wide as the number of BH providers doing them. This results in children and families having to tell their story repeatedly, as well as providers duplicating services that have already been provided. However, to place an arbitrary cap without mandating standardized assessments is harmful for the PCSA as we receive children who may have already had multiple hours of assessments in the year, with no success, and now we must have them re-assessed in order to access services. The State did try the SOQUIC, but it never was mandatory and never gained traction. True tool standardization would need to encompass not only the tool itself, but mechanisms for the PCSA and caregivers to know if another assessment has been completed, where it was completed, and for coordination between BH providers to share and accept that information.

25. 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?

It is not readily apparent at this time that the MCPs even understand the above EBPs, especially ones related to BH, let alone to assist in increasing access and/or capacity. Therefore, again, education and understanding of the available resources is important. Access to services (without lengthy waitlists) is needed. Growth of the service array continuum that is available in our communities and in our State is needed. Homebased services vs. standard OP services is needed on a much larger scale due to the challenges faced by our children, families, and communities, along with development of the workforce in order to deliver these much-needed services. In addition, billing codes and reimbursement needs to be such that BH providers can sustain quality, evidence based/informed programs and services – instead of running at a deficit or relying on PCSAs to supplement payment for non-billable services that are required of an evidence based/informed program.

Also, as we are being tasked through Family First of utilizing evidence based and evidence informed treatment models, changes need to be made to the billing structure to allow providers to bill for the correct menu of services that will produce positive outcomes for our youth. PCSAs are often off-setting non-billable costs in order to keep these programs going. There are too many fidelity functions that are not face-to-face with the client that cannot be billed. In addition, research populations may be too restrictive, and our children do not directly meet their criteria. How will ODM and the MMC entities assist us in evolving programs to meet this "nontraditional – outside of research population" children that may need modified treatment services?

Care Coordination/Care Management

Care coordination/care management

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26. 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)*

We have found PFK to be helpful in assisting us in managing our children with complex health conditions.

27. 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)

Any child in the custody of a PCSA should be included in a "higher expectations" model due to their trauma, complex needs, and often, multi-system involvement.

Special populations
28. 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

Yes – with all of the above categories. Children in custody with complex needs and multi-system involvement require models of care coordination, medical care, etc. that are fluid and take into account the complexities of their numerous needs and the system who is tasked with ensuring their

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safety, permanency and well-being. Again, in order to do this, the individuals involved need to have an understanding of this population that goes beyond the surface, and really begins to tap into the services needed to produce positive health/BH outcomes for these children.

Cross-system collaboration

29. 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 an managed care plan.

There need to be coordinated, consistent meetings held by the State to have ongoing conversations as to how this process is going, suggestions for improvement, changes that need made, etc. PCSAs and other systems needs to be informed regularly as to changes that are being made so that we can assess our day to day workflows and make changes as necessary. Prior to the change in administration, we relied on Vorys to communicate any upcoming changes, etc. to us. Without that in place, there will be gaps in communication between system partners, which can lead to mistakes, frustration, etc.

Population Health Considerations

30. What population health measures (e.g., infant mortality, smoking, cardiovascular disease) could the state target in its procurement to have the greatest impact?

Infant mortality, substance abuse, and BH. Also, positive tox infants and the corresponding physical/BH issues that can impact those children for life. In addition, those populations with increased trauma exposure (which includes children in custody, justice involved populations, veterans, etc.).

31. 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?

We believe it could vary by measure. We feel unable to answer this question fully, as we do not feel we have seen the full array of what each entity can/will do to address these measures.

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:

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

Positive health outcomes for the population served.
Children being served successfully in the community (exiting custody and remaining out of custody).
Satisfaction with services from system partners.
Satisfaction by individuals/caregivers regarding services provided, access to services, etc.

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33. What measures (current or proposed) have the highest value for measuring system/managed care plan performance? Identify the measures and why they are valuable.

All of the above are believed to be valuable, as they indicate in their own way if our children are able to access needed services, if they are effective services, and if those receiving/attempting to coordinate those services are pleased with the MCPs performance.

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

N/A

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

See above.

General Feedback

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

To have MMC actually assist us in providing improved care for our children and families, rather than being a barrier and potentially causing worse care to be delivered. And, if this not possible, to allow PCSAs the choice to keep a child on Fee for Service (FFS) Medicaid.

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

An assessment of gaps in the service continuum not only for children in custody, but those at risk of entering care.

Ongoing, open conversations with PCSAs and providers to develop new, creative ways of serving this population.

Please also refer to the PCSAO Recommendations that follow.

PCSAO
PUBLIC CHILDREN SERVICES
association of ohio

Safe Children, Stable Families, Supportive Communities

PCSAO Core Managed Care Group's Preliminary Recommendations
for Ohio Department of Medicaid and Ohio Department of Job and Services
as of June 14, 2019

Purpose: Serve as an Ad Hoc Committee to the Board of Trustees to make recommendations pertaining to the Medicaid Managed Care procurement process to the Ohio Department of Medicaid.

Members include: Tim Schaffner, Trumbull; Jeff Felton, Medina; Matt Kurtz, Knox; Aunie Cordle, Fairfield; Johanna Pearce, Fairfield; Chip Spinning, Franklin; Elisha Cangelosi, Franklin; John Fisher, Licking; Kim Wilhelm, Licking; Patty Harrelson, Richland; Renee Blakenship, Richland; Cathy Hill, Athens; Angie Verity, Athens; Jewell Good, Montgomery; Cassandra Holtzmann, Crawford; Andy Nigh, Crawford; Ebonie Jackson, Lucas; Donna Seed, Lucas; Anne Gross, Hamilton; Nina Lewis, Hamilton; Margie Weaver, Hamilton; Scott Britton, PCSAO; Angela Sausser, PCSAO; in partnership with Kristi Burre, ODJFS CST

Category	Recommendations
Structure:	**Carve In/Carve Out for Children in Custody:** - Allow PCSAs to choose if child should be enrolled into a managed care plan vs. as FFS - If mandatory enrollment remains, build a "safety valve" that allows PCSAs to disenroll a child from managed care and enroll in FFS **Number of Plans for Children in Custody:** - Allow PCSAs to choose how many plans to work with (most prefer 2-3 plans) - Allow PCSAs to have the ability to switch plans when needed **Carve In/Carve Out for Behavioral Health Services**: - Create a specialized category for kids in custody that mimic the pros in FFS but for MCO requirements/expectations - Recommend a customer service survey to study to what extent the MCPs are meeting all the needs of children in custody - Ensure no cost shift occurs to a PCSA for behavioral health services, including residential services and the need for such services to be unbundled **Number of Plans for BH Services**: - No limit on the number of managed care plans but that they must have the competency to serve kids in custody and meet their needs (see above under carve in/carve out for BH services)

Service Array:	**Comprehensive Primary Care (CPC)**: - Allow PCSAs to choose when and if any child in custody should participate in a CPC model **Care Coordination Recommended Components**: - Behavioral health services beyond physical health for very intense, multi-system youth (services beyond just securing a placement) - Be able to identify and secure services that would assist with preventing placements - To fully share all information about the child with the PCSA and with the other members of the team - Assistance with appeals and denials - Assistance with medication issues - Assist the PCSA to secure needed placement to meet the child's need and to pay for it -- assistance, not approve - Immediate access to a 24/7 crisis team - *"It is not the coordination that is hard, it's the service array that is hard to access, find, obtain, and/or get approval"* **Behavioral Health**: The following services are in PCSAO's Continuum of Care Reform plan and recommended to be a Medicaid service and included in the state's plan: - High Fidelity Wraparound - Short-term crisis services, including mobile - Respite – broaden its utilization and approaches; in-home, community, out-of-home - Peer support beyond recovery including youth peer support - Therapeutic, treatment foster care - Psychiatric Residential Treatment Facility - Modify the requirements for IHBT staffing to expand capacity for this critical service - Intermediate to Long-Term Day Treatment/PH day program with longer duration; all-day program; need to educate providers on how this fits into the service array; serve as an alternative school program; with evening reporting; limited availability (1 year wait list) - Trauma Informed Care evidence-based interventions such as NMT Mapping, EMDR therapy

Data/Outcomes:	**Performance Measures/Outcomes:**
	- Performance measures for MCPs need to align with those for the children services system specifically related to safety, permanency, and well-being, including:
	  - Quality of outpatient services
	  - Changes in the number of providers

	- Duration of services - The following measures should be added to the MCP Pay for Performance incentive plan to help improve access for children such as (1) measure of length of time from identification of need to treatment; (2) CAHPS for Children with Chronic Conditions, experience of care measures for MCPs - Ohio Scales but needs to be aggregated at the state **Data Recommendations**: - EPSDT data are aggregated to benchmark needs across the state - MCPs complete a Business Associate Agreement with PCSAs and provide electronic clinical data exchange with PCSAs of EPSDT Clinical Profile for each child in custody (health passport) and Assessment, Care Plan, and Utilization Review data from the MCP care management IT system. - Access to claims activity/data - State hearings, appeals, denials notification portal – allow immediate notification to PCSAs; able to the status; results - Be able to compare a child to other children with similar needs in custody
Other Contract Requirements:	**Incentives:** - No incentives for PCSAs, children in custody or foster parents - Provide incentives to providers to incentivize behavioral health providers to maintain a child in care or assist with stepping down their level of care - Develop specific measures that we would want providers to be incentivized in meeting that would benefit children in custody **Contract Requirements:** - Require a prospective review of psychotropic medications vs. prior authorization for medications - MCPs should be required to comply with the OAC rules related to health care requirements, assessments, timeframes, coordination, and information sharing for children in custody (OAC 5101:2-42-66; 5101:2-42-66.1; 5101:2-42-66.2). - Ensure all children in custody are provided a standardized, evidence-based EPSDT clinical assessment of their health care needs (also for their parents) and that PCSAs are provided an EPSDT profile - Include access requirements for specific pediatric providers, particularly child psychiatrists and psychologists in their contract with MCPs.

	- Specify that children and families involved in the children services system are given priority for any behavioral health care services with a wait list.

Documents Reviewed:

a. Managed Care Recommendations (Dec. 2014)
b. BH Services Recommendations (Dec. 2014)
c. BH Managed Care Structure Recommendations (Mar. 2015)
d. JFS Healthcare Rules (Feb. 2018)
e. Children's Continuum of Care Reform Plan (May 2018)
f. Memo to ODJFS regarding CFSR PIP (June 2018)
g. Comprehensive Primary Care (May 2019)
h. BH Stakeholder Update & Discussion Concept Paper (May 2019)
i. Medicaid Support for Children's Services Transformation (May 2019)
j. Enhancing Support for Multi-System Youth (May 2019)
k. Federal Guidance re: Institutions for Mental Diseases (IMD) (May 2019)

Contact Information:

For additional information or any questions, please contact Angela Sausser, PCSAO Executive Director, at Angela@pcsao.org or (614) 224-5802.