Response to

# Request for Information
# ODMR20210019
# Ohio Medicaid Managed Care Program RFI #2
# Feedback Regarding Ohio Medicaid's Future Managed Care Program

## Due March 3, 2020 at 4:00pm EST

Presented to

## Ohio Department of Medicaid

Submitted by

## Aetna Better Health® of Ohio

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Addressing member needs in a holistic way is key to improving the quality, health outcomes, and experience of individuals served by managed care organizations (MCOs) and providers. Aetna Better Health Inc. dba Aetna Better Health of Ohio (Aetna) is a member-devoted, person-centered organization that supports individuals as the driver of their health journey; they are at the center of all decisions in their care.

## a. How ODM can support MCOs and providers to become person-centered organizations dedicated to improving the experience of individuals they serve

Addressing members' social needs is an integral part of a holistic approach to person-centered care. We know 90 percent of Medicaid members have 1 or more social needs, and that 41 percent have 3 or more social needs that may include housing, transportation, food, and educational and vocational needs.

The Ohio Department of Medicaid (ODM) can support MCOs and providers to become person-centered organizations by incentivizing the development of member-directed comprehensive individual care plans, which go beyond covered services. One mechanism for such incentives may be the use of value-based purchasing (VBP) arrangements that drive quality of care and individual-based outcomes. Using the person-centered care planning approach, MCO care managers (CMs) and provider staff can facilitate discussion with members to identify goals and objectives related to the full set of factors that impact health. CMs and provider staff can use a comprehensive electronic health record to seamlessly build on the work of others on the care team in developing care plans that contain supports to meet the member's social needs and address barriers, such as access to food boxes, securing transportation to appointments, and safe and secure housing and utility needs, and creating plans for educational and vocational programs.

ODM could support the MCOs and providers in identifying and collaborating to address the challenges, gaps, and barriers that will change health outcomes for well-defined populations, such as addressing gaps in available providers; scarcity of child psychiatrists; gaps in access due to transportation barriers; increasing housing opportunities; and collaborating with various state agencies such as the Ohio Department of Youth services to improve communication and care coordination. ODM can support the MCOs and providers in improving the experience of the individuals they serve by including social services such as food, education, and respite, through in lieu of services or as a covered service benefit.

## b. Strategies MCOs can use to engage members into wellness activities known to improve health outcomes

MCOs can use the following strategies to engage members into wellness activities known to improve health outcomes:

- **Community health workers (CHWs) and community-based organizations (CBOs):** CHWs are resources available to help direct members with any issues they may need and serve as member advocates. CBOs engage members to understand their individual and unique needs and can integrate resources between community supports and MCO benefits. CHWs and community-based peer support workers should serve as liaisons between the member, CBO resources, and the MCO.
- **In-person visits:** Care managers should complete face-to-face visits in the member's home, in providers' offices, or other confidential settings for members who need additional support. Community-based peer support workers and CHWs should conduct face-to-face visits in a community setting of the member's choice with a focus on helping members achieve their person-centered goals for their health and wellness.
- **Provider coordination:** MCOs should facilitate follow-up appointments for members and assist with selecting a primary care provider (PCP).
- **Text messaging:** Text messaging can send routine reminders to members to support their health goals, including topics such as weight management, diabetes, cervical cancer screening, opioid use, prenatal and postpartum care, well-child visits, breast cancer screening, flu shots, adult body mass index, controlling blood pressure, and chlamydia screening. Text campaigns can be personalized and serve as virtual health coaches, allowing members to interact and be educated on their specific conditions.
- **Social media offerings:** MCOs often offer outreach and engagement opportunities through social media platforms, such as Facebook.
- **Phone:** Care managers can reach out to members with certain risk factors to offer support and resources to engage members in their health care. High-risk members should receive regular outreach for complex care management support.
- **Mail:** MCOs can mail information to members using condition-specific newsletters that contain information about local supports and resources that can help them reach their health goals.
- **Website:** The MCO can provide access to a comprehensive health plan website including links to resources such as health assessment and self-management tools.
- **Value-added benefits:** MCOs can use value-added benefits to help engage members in their health care and give them an opportunity to self-direct their benefits based on choice and selection.

## c. How MCOs and providers can leverage technology to communicate with individuals about wellness activities, benefits, and health care taking into consideration Ohio's geographical structure including rural vs. urban-specific needs and potential communications barriers (e.g., lack of phone and internet access)

MCOs and providers can maximize technology resources to engage individuals in their health in their neighborhoods as close to their homes as possible. MCOs can leverage technology to communicate with and engage individuals immediately upon enrollment with automated welcome calls, including an opportunity to complete a health risk questionnaire to inform the MCO of their conditions and needs. In addition to giving members access to call the MCO 24/7/365, MCOs and providers can build websites that offer a wealth of resources and educational information. The MCO website should be a single, comprehensive source of easy-to-navigate information for members' needs, including a secure member portal, covered and value-added services, provider search, care management programs, important telephone numbers, the member handbook and member rights, health education and prevention

information and programs, a community resource library, and member newsletters. The MCOs can offer a secure member portal located on the MCO's website and via a mobile application for smartphones. A secure member portal should be easy to navigate and can include a member's individual benefit information and their personal medical records, services, and service authorization status with available support for logging in and navigating the site.

MCOs and providers can leverage technology to monitor and track completion of community-based referrals, addressing needs such as assistance with food, housing, and transportation with a closed-loop referral system. Staff who work at the CBOs can refer members using the closed-loop platform to identify the closest viable resources to meet each person's needs. Once the person has received assistance, the CBO staff can document the referral and its closure, creating a closed-loop tracking system that supports an MCO's ability to help members achieve healthy outcomes.

### Expansion of Telehealth

To address Ohio's geographic structure, ODM should consider supporting the enhancement of telehealth to mitigate limited access to services in rural areas of the state and transportation issues. **Aetna recommends expansion of the Ohio telehealth system to include access to an authorized clinical site for members to receive care in every rural community.** Telehealth services promote the integration of physical and behavioral health care and enable provider-to-provider consultation between PCPs and specialists. Telehealth services are delivered in real time, through interactive live audio video technology offered by allowable provider types including physicians, physician assistants, advance practice registered nurses (APRN), nurse practitioners, APRN-certified nurse midwives, APRN clinical nurse specialists, licensed psychologists, and licensed clinical social workers. In addition, Aetna has expanded our telehealth program to include behavioral health providers and non-physician services like individual therapy and coaching.

### Remote Patient Monitoring

MCOs and providers can leverage remote patient monitoring (RPM) technology for members with specific chronic or high-risk diseases, such as congestive heart failure. Members who take part in RPM can receive an in-home remote monitoring technology package to collect and submit biometric data daily to the MCO. If submitted biometric data is deemed out of range, the MCO could notify the practitioner to implement appropriate interventions.

### Broadband Expansion in Southeast Ohio

Aetna health plans in other Appalachian states such as Kentucky, Pennsylvania, Virginia, and West Virginia face some of the same unique challenges experienced by Southeast Ohio, including living in large rural areas with transportation and provider access challenges. We know that telehealth solutions in these regions can be limited due to members having difficulty accessing internet services, so we have experience collaborating with broadband companies and state governments to improve such access. MCOs and providers can support and leverage the broadband expansion as it develops in Southeast Ohio.

## d. How MCOs and providers can support efforts to reduce the impact of health care disparities, such as geography, race or ethnicity, or income levels

MCOs and providers can support efforts to reduce the impact of health care disparities, such as geography, race, ethnicity, or income levels by understanding the disparities, community variations, and resources available, and providing access to holistic, person-centered services. Key to this effort is having the appropriate type and amount of staff in the local community, including community-based organization partners, to engage and support members such as CHWs, care managers, and peer support specialists.

## e. How MCOs could support providers in implementing care delivery strategies that are culturally relevant and foster respect, trust, and empathy. How this would be monitored

Training, technical assistance, and ongoing support is critical for the MCOs to support providers in implementing care delivery strategies that are culturally relevant and foster respect, trust, and empathy. The use of non-traditional VBP contracts should be encouraged to incentivize providers to engage and develop culturally relevant practices. Aetna recommends MCOs support providers through the following:

- Requiring and providing cultural competency training for providers upon enrollment into the network
- Providing comprehensive trauma training online, in person, and via virtual meetings to help providers better understand the trials and life of the member
- Facilitating poverty simulation experiences to encourage empathy, respect, and trusting relationships between members and stakeholders
- Supporting the development of individual member care plans that include their strengths and culture throughout the lifespan

MCOs could monitor these delivery strategies through audit tools, incentives, quality metrics, member complaints and grievances, potential quality of care concerns, dashboard review (e.g., reviewing cultural barriers that may exist to accessing care resulting in unnecessary visits to the emergency department), and through feedback to the plan via Member Advisory Committee meetings. MCOs could also achieve the National Committee for Quality Assurance Distinction in Multicultural Health Care by ensuring provision of culturally and linguistically appropriate services to members.

**Managed Care Structure**

2. **Managed Care Organizations and Service Area —** ODM intends to procure MCOs as a foundational component of its Medicaid managed care program. MCOs will be responsible for administering and managing Medicaid benefits under a full risk contract, including behavioral health services, for all populations, other than pharmacy and except for the behavioral health benefit for children served by multiple state systems or with other complex behavioral health needs (see questions 3 and 13 below).
   a. ODM is considering allowing MCOs to bid on specific regions. Please provide your interest in a regional award or awards versus a statewide award and explain your reasoning.
   b. Should changes be made to the currently defined MCO geographical regions? If so, what should ODM consider when redefining the regions?

Aetna acknowledges managed care organizations (MCOs) will be responsible for administering and managing Medicaid benefits under a full-risk contract, including behavioral health services, for all populations other than pharmacy and except for the behavioral health benefit for children served by multiple state systems or with other complex behavioral health needs.

## a. Regional Award(s) versus Statewide Award

Aetna supports a model in which MCOs would have an opportunity to bid on both specific regions and statewide. Regional awards would enable the Ohio Department of Medicaid to manage an appropriate number of MCOs serving each region and ensure balanced market share to enhance the members' and providers' experience.

## b. Geographical Regions

Aetna does not foresee a need to modify the currently defined geographical regions. We believe the current structure of the Central/Southeast, Northeast, and West regions is a fair composition of the state's demographic and population makeup. In particular, the creation of additional regions, without adequate contract guardrails, could result in an insufficient number of MCOs in regions with network development and/or viable membership challenges.

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**Managed Care Structure**

3. **Pharmacy Benefits Management** — As directed by the Ohio General Assembly, ODM will engage with a single pharmacy benefit manager for the managed care program. The pharmacy benefit manager and ODM will be primarily responsible for managing and administering the pharmacy benefit for MCO members. This may include, but not be limited to, maintaining the unified preferred drug list, conducting utilization management, administering pharmacy clinical programs, creating and maintaining the pharmacy network, processing pharmacy claims, reimbursing pharmacy providers, integrating medical and pharmacy claims, conducting data analytics, and exchanging data. The MCOs will receive data exchanges/extracts for their Medicaid members from the pharmacy benefit manager.

   The MCO responsibilities may include having an agreement with the pharmacy benefit manager, primarily for data exchange; coordinating and cooperating with the pharmacy benefit manager and ODM to optimize the provision and utilization of pharmacy benefits; providing member information and education and integrating pharmacy data to support member and provider experience; integrating pharmacy data into the MCO's care management and clinical programs; coordinating with the pharmacy benefit manager and ODM to enhance prescriber and pharmacy provider engagement and pharmacy clinical programs such as medication therapy management; having the option to establish value-based payments for pharmacies; managing the medical benefit; and exchanging data with the pharmacy benefit manager and ODM.

   a. What suggestions do you have regarding the coordination of MCO and pharmacy benefit manager clinical programs?

   b. How could ODM better align the pharmacy and medical benefits, including physician administered drugs, to improve outcomes for individuals?

   c. Describe best practices for MCO exchange and integration of pharmacy data with a pharmacy benefit manager.

   d. Please describe the impact of the above model for Medicaid managed care on the provision of Medicaid and Medicare pharmacy services to MyCare members. Would you suggest that ODM use the same model for the Medicaid pharmacy benefit for MyCare members? Please explain your rationale.

Aetna recognizes the single pharmacy benefit manager (PBM) for the managed care program in Ohio will be one of the first in the nation and looks forward to collaborating with the Ohio Department of Medicaid (ODM) and the selected PBM with this implementation. Coordination between the managed care organizations (MCOs) and the PBM clinical programs will be critical in ensuring continuity of care and positive health outcomes for our members.

## a. Suggestions regarding the coordination of MCO and pharmacy benefit manager clinical programs

Aetna has been successfully collaborating with our PBM to provide high-quality services to our members in Ohio since 2014. Together, we jointly serve our members through our clinical programs designed to meet the needs of our members. Critical to our success is real-time access to member pharmacy information to enable immediate issue resolution for our members, and the receipt of daily pharmacy claims data that allows us to run targeting protocols to support identification of members for engagement into clinical programs conducted by our Pharmacy, Utilization Management, Quality Management, and Care Management teams.

Aetna offers the following recommendations to ensure coordination of MCO and PBM clinical programs:

- Selection of a sophisticated, proven, experienced PBM through the solicitation process that is well-established in Ohio and in serving Medicaid members
- Establishment of a robust pharmacy network of providers that includes pharmacies outside of the state (specifically in neighboring states) to ensure members have access to medications
- Given the years of experience MCOs have working directly with PBMs, ODM could consider having MCO participation on the selection body to award the PBM solicitation
- Consideration by ODM to include the MCOs in the development and maintenance of PBM processes and pharmacy network, including input on the unified preferred drug list (PDL), utilization edits, and coverage criteria; collaboration on administering pharmacy clinical programs and program data exchanges; identification and implementation of best practices for integration of medical and pharmacy claims data analytics; and data exchange practices and safeguards
- PBM provision of accurate and timely data, tools, and resources to support MCOs' ability to assist members and prescribers, such as the following:
  - Access to accurate drug coverage (PDL) and clinical criteria for coverage of medications
  - Alerts on pharmacy drug coverage changes prior to implementation to support affected members in need of transition
  - Ability of PBM to accept MCO medical data transfers to allow SmartPA (prior authorization) functions during claims adjudication
  - Access to dedicated Ohio MCO PBM staff to assist with day-to-day pharmacy issues experienced by our members, such as eligibility issues and access to medications
  - Presence of an MCO PBM escalation protocol in case the PBM's pharmacy help desk is not responsive or is unable to assist the member and provider
  - Access to PBM pharmacy PA case information (approvals and denials) to assist members and prescribers
  - Access to a real-time claims adjudication system to understand current member claims adjudication needs and accumulators if applicable
  - Ability to work with key PBM staff (designated team) to assist members with special needs that are having difficulty getting coverage by the State PBM
- PBM delivery of daily pharmacy data files to the MCO to support MCO clinical programs and services with key data elements discussed and agreed upon by the MCOs and the State PBM; prescriber data is needed on the pharmacy claims for care coordination purposes
- If the PBM provides clinical programs, the PBM should work with the MCOs to identify how information about these programs (members or prescribers touched) can be shared to help MCOs coordinate their pharmacy and care management programs
- The PBM should be required to provide real-time access for the MCO to view targeted member pharmacy data in the PBM's reporting systems, thus supporting MCOs' ability to assist members in our clinical programs and to resolve issues
- MCO Medical Management teams need to have the ability to work with PBM and pharmacy providers on managing and coordinating member care, especially those in need of a selective provider program or lock-in program
- PBM should conduct a monthly Joint Operating Committee (JOC or operations) meeting to discuss issues experienced by members and providers, as well as to educate MCO Pharmacy and other key MCO staff on benefit and clinical programs changes. Additionally, the PBM should conduct MCO implementation meetings to provide MCO Pharmacy teams with new PBM program information.
- ODM could consider requiring both the PBM and the MCOs to conduct clinical program oversight meetings to ease member navigation of programs
- PBM should be required to educate MCO Pharmacy staff on the PBM's operational processes and clinical programs so they can be shared with appropriate MCO Medical Management teams and used to coordinate care and services for members and providers

- MCOs should have ability to drive clinical programs and have value-based payment contracts with regional pharmacies (contracting with pharmacies within the PBM's network)

The clinical integration of MCO pharmacists (e.g., pharmacy directors and clinical pharmacist advisors) and other MCO clinical team members (e.g., medical directors, care managers, etc.) is critical to drive efficiency in total spend (pharmacy and medical) and effectiveness in clinical outcomes. Additionally, MCO staff must be able to work with medical and pharmacy providers to enhance clinical integration in order to improve member care.

## b. How ODM could better align the pharmacy and medical benefits, including physician-administered drugs, to improve outcomes for individuals

ODM's alignment of the pharmacy and medical benefits, including physician-administered drugs, is critical to improving outcomes for individuals. Aetna recommends consistent formulary and coverage policies across both pharmacy and medical benefits, including the clinical review of drugs, to drive consistent member care and promote evidence-based clinical outcomes. The PA teams should review all outpatient medications using the same clinical criteria regardless of whether the medication is acquired through the pharmacy or medical benefit. This consistent coverage will promote the use of the most clinically appropriate drugs first. Additionally, Aetna recommends the following:

- MCO staff have access to accurate drug coverage (PDL) and clinical criteria for coverage of medications to better assist members and prescribers and ensure appropriate medication coverage
- MCO staff have access to pharmacy PA case information regardless of coverage approval or denial to assist members and prescribers with next steps
- The daily pharmacy claims file should contain all required data fields to allow for use by Medical Management teams; key data elements should be discussed and agreed upon by the MCOs and the State PBM; prescriber data is needed on the pharmacy claims for care coordination purposes and medication coverage decisions
- Key MCO staff (e.g., care managers, pharmacists, and Utilization Management and Member Services staff) need to have access to the State's PBM claims system to view real-time claims adjudication in order to assist members in addressing medication issues, and to better understand member current medication status, which can be applied during utilization or care management activities

## c. Best practices for MCO exchange and integration of pharmacy data with a pharmacy benefit manager

Nationally, Aetna has established best practices for MCO exchange and integration of pharmacy data with our PBM, which supports our connection to members across the spectrum of services we provide. With accurate and timely data, MCO pharmacies and Medical Management teams can implement care coordination and utilization management programs that impact members and providers in their communities. The clinical integration of pharmacists employed by the plan (e.g., pharmacy directors and clinical pharmacy advisors) with other MCO clinical team members (e.g., medical directors, care managers, and social workers) and our medical and pharmacy providers is critical to driving efficiency in total spend (pharmacy and medical) and effectiveness in health outcomes.

Aetna's best practice recommendations include the following:

- The PBM should be required to work with MCOs to establish secure medical data transfers to allow SmartPA functions during claims adjudication
- The PBM should provide a daily pharmacy claims file that contains all required data fields to allow for use by Medical Management and Quality Management teams; key data elements should be discussed and agreed upon by the MCOs and the State PBM. Pharmacy claims should include prescriber and pharmacy provider data to support care coordination.

- Data exchange and integration must be timely (daily) to enable the MCO to help the member access care and resolve barriers
- If a member out-of-pocket maximum exists, the MCO will need to have access to member pay information to assist members, preferably via a real-time system
- The PBM should explore submitting data to an Ohio health information exchange/network
- The PBM should conduct monthly JOC meetings to discuss issues experienced by members and providers, as well as educate MCO Pharmacy (and other key staff) of benefit changes and clinical programs. Additionally, the PBM should conduct MCO implementation meetings to provide MCO Pharmacy teams with PBM program information.
- The PBM should dedicate key PBM staff to MCOs to resolve data integrity and timeliness issues. Issues and resolutions should be reported back to the State.

## d. The impact of the above model for Medicaid managed care on the provision of Medicaid and Medicare pharmacy services to MyCare members. Whether ODM should use the same model for the Medicaid pharmacy benefit for MyCare members. Explanation of your rationale.

As the Medicaid managed care and MyCare programs are separately regulated and controlled by different government programs, Aetna would not suggest the same model for the Medicaid pharmacy benefit for MyCare members. This could complicate and disrupt coordination of care (single transaction coordination of benefits) as the Medicare Part D networks may conflict with the Medicaid network. Navigation of care could become difficult for both the member and the MCO. For example, consider the following:

- Medicaid pharmacy benefits and Medicare Part D benefits are managed by a completely different set of regulations. The MCOs that have a MyCare plan have vast knowledge of Medicare Part D rules and regulations such as those found in Chapters 6 (Part D Drugs and Formulary Requirements) and 7 (Medication Therapy Management and Quality Improvement Program) of the Prescription Drug Manual, which may be different or conflict with the State Medicaid requirements.
- Part D formulary requirements are more rigorous compared to Medicaid formulary requirements. Our Aetna MyCare plan in Ohio recently went through a Centers for Medicare & Medicaid Services (CMS) performance audit in the fall of 2019 and received no enforcement actions from CMS. The MCOs have the required experience necessary to stay compliant with the Part D program.
- The members who are in the Medicare-Medicaid Plan (MMP) tend to be high utilizers and have health conditions that are very fragile. These high-acuity members require hands-on care by Care Management teams that work very closely with the Pharmacy team. If an issue arises related to a medication, the case manager has immediate access to the plan pharmacist for urgent resolution. Providing immediate coordination and resolution can mean the difference between a member staying healthy at home versus being admitted to the emergency department. Transitioning PBM activities to a separate entity can create delays in timely resolutions and responses that our members will receive.
- The current model of having a single MCO (and single PBM) for both the Medicare and Medicaid benefit allows our members to only show one card to the pharmacy; the claims for either a Part D drug or Additional Demonstration Drug (ADD) are adjudicated in the PBM claim system using single transaction coordination of benefits. This process removes the burden of determining which PBM to bill for Part D drugs and which to bill for ADD file drugs from the member and the pharmacy, reducing administrative barriers to needed medications. If MMP members were to have a separate PBM and MCO, this process could become cumbersome for members and Pharmacy staff, as it may require members to show two insurance cards and may create unnecessary delays in determining whether coverage should be under the Part D or the ADD benefit.

**Managed Care Structure**

4. **Fiscal Intermediary** — Accurate, timely and actionable data are fundamental to the effective operation of a Medicaid program. Currently, ODM has to conduct special analyses and make additional efforts to collect data from several managed care plans. At the same time, providers report that the inconsistency in business processes across managed care organizations requires additional resources and time that could be better spent on patient care.

   ODM plans to contract with a fiscal intermediary to conduct intake and pre-process claims for both fee-for-service Medicaid and managed care. All claims, either submitted via portal or electronic data interchange (EDI), will come into that single fiscal intermediary. If a claim is for an individual enrolled in an MCO, the fiscal intermediary will edit the claim to specific Strategic National Implementation Process (SNIP) level edits and then send the claim to the correct MCO. The MCO will adjudicate the claim, pay the provider and send a response back to the fiscal intermediary, who will send the response to the provider. The MCO will be required to provide status updates to the fiscal intermediary to report to the provider before adjudication. The MCO will provide data back to the fiscal intermediary for the 835 Electronic Remittance Advice and a "paper" Remittance Advice for the Provider Portal. All these interactions will take place through ODM's System Integrator, not directly between the fiscal intermediary and the MCO.

   Similarly, ODM intends that all prior authorization requests will come into the fiscal intermediary. If the request is for an individual enrolled in an MCO, the fiscal intermediary will forward the prior authorization request to the MCO for determination and response back to the fiscal intermediary.

   a. Please identify any potential barriers to implementing this model from the MCO and/or provider perspective and proposed solutions.

   b. One key goal of this model is to provide a consistent experience for providers across MCOs and fee-for-service. Please describe the advantages and disadvantages of requiring the MCOs to comply with/apply fee-for-service claims processing edits and rules. Please identify the types of edits/rules that should be determined by the MCO, including the rationale.

Aetna understands the Ohio Department of Medicaid's (ODM) goal to improve administrative efficiencies and the providers' concerns to reduce the administrative burden associated with the claims processing function across managed care organizations (MCOs). Introducing a common fiscal intermediary will require ODM, providers, and the MCOs to address multiple administrative challenges. Assuming these challenges are addressed, ODM's use of a fiscal intermediary may result in meaningful efficiencies for ODM and providers, such as a common data warehouse for the adoption of a common set of provider notices that could be used by all MCOs. This role could function as a common systems integrator in support of the utilization management, claims processing, fraud, waste, and abuse (FWA), and provider incentive program, as well as encounter management data used by the State for rate setting purposes. Use of a fiscal intermediary would also support the use of common provider training standards and support the alignment of numerous MCO business processes.

## a. Potential barriers to implementing this model from the MCO and/or provider perspective and proposed solutions

Our response to **Question 4a** covers potential implementation barriers related to utilization management, prior authorization (PA), claims administration, and value-based partnerships.

## Potential Utilization Management and Prior Authorization Implementation Barriers

Aetna sees the following utilization management and prior authorization barriers ODM and the MCOs will need to address with the adoption of a common fiscal intermediary:

- Use of a fiscal intermediary to disseminate provider requests to the MCO poses a challenge related to timeliness of processing those requests. Additionally, each MCO will manage to a unique provider outreach process for requesting additional clinical information that will affect providers. Having a common fiscal intermediary disseminate information to the providers may result in role confusion when an MCO is outreaching to a provider for additional and separate information.
- Individual MCOs may be applying unique or different prior authorization requirements and rules from other MCOs. ODM may need the fiscal intermediary to communicate individual MCO prior authorization requirements and rules to the providers to alleviate potential confusion.
- It will be imperative for the fiscal intermediary to have the ability to seamlessly connect an individual claim, which is passed through to the MCO, to the applicable service authorization the fiscal intermediary previously received. If the fiscal intermediary cannot align or match a unique claim to a specific service authorization, there is potential for claim to authorization mismatch. This mismatch will potentially confuse providers and generate unintended rework in order for the providers to be paid correctly.
- For the majority of current Medicaid programs, providers interact with each MCO to reconcile service authorizations where the provider did not obtain or receive prior approval, but the member received the service. ODM and the fiscal intermediary would need to clarify whether these services will be automatically denied and to disallow the provider from requesting payment for what could be a clinically appropriate service. If ODM and/or the fiscal intermediary adopt this approach, ODM may unintentionally limit reimbursement for services, such as inpatient hospitalization where providers are taking care of sick patients and not getting prior approval.
- In situations where a service may be denied, ODM and the fiscal intermediary will need to establish a common process for communicating this denial information to the provider and confirmation to the MCOs. This communication could originate from the MCO or the fiscal intermediary, but the provider communication process should be managed in a consistent fashion.
- ODM and the fiscal intermediary will need to determine whether providers will be permitted to engage in peer-to-peer interactions associated with services denied by the MCO. If these interactions are supported, the fiscal intermediary's role and accompanying communication responsibilities need to be defined and shared with providers and the MCOs.

## Potential Claims Administration Implementation Barriers

Aetna sees the following claims processing opportunities and challenges associated with the adoption of a fiscal intermediary:

- ODM and the MCOs will need to clarify the process and related roles for managing provider communications or phone calls regarding claim questions as well as administrative appeals on denied claims.
- ODM and the MCOs will need to develop administrative standards, rules, and processes associated with the editing, validating, and transferring of claim information in order for the MCO to accurately pay a claim.
- ODM, the fiscal intermediary, and the MCOs will need to develop a standard administrative process detailing the extent to which the MCO will be required to provide claim status updates to the fiscal intermediary to report to the provider before adjudication. MCOs adjudicate and pay claims daily, so this process would need to include a procedure regarding the frequency the MCO will be required to provide status updates that would not impact an MCO's ability to pay claims in a timely manner.
- The MCOs will need to work with ODM to develop a standard process and a common set of response requirements that the MCO will submit to the fiscal intermediary once a claim has been paid. ODM

will also need to develop a process for coordinating how the fiscal intermediary will issue paper checks to providers that are not enrolled in the electronic funds transfer process.
- ODM may want to establish time guarantees for the intermediary to report claim-related information to the MCO to ensure timely claim adjudication.
- ODM may want to determine rules or procedures for when an MCO can interact directly with a provider for the purpose of adjudicating a claim.
- When providers resubmit corrected claims as part of the reconsideration process, ODM will need to define how this information is communicated to the fiscal intermediary and to the MCO.

The fiscal intermediary will also need to maintain FWA processes and systems that align and support claim administration efforts with each MCO. These compliance programs should include program integrity processes designed to achieve the following: identify potential fraud and/or abuse of providers or members and reduce or neutralize the deliberate misrepresentation of need or eligibility; or identify the submission of false information concerning costs or conditions to obtain reimbursement or certification of services, PA of services, or claim payment for a service that was never delivered or received.

### Potential Value-based Partnership Implementation Barriers

Aetna sees the following value-based partnership challenges and opportunities associated with the adoption of a fiscal intermediary:
- Adding a fiscal intermediary to the administrative structure will impact an MCO's ability to administer value-based partnerships and alternative payment structures. ODM may have to engage MCOs in developing a common payment methodology and incentive structure to support value-based payments to providers. An MCO's primary care medical home (PCMH) reimbursement arrangements commonly target providers to improve quality performance through MCO care coordination models. For example, ODM's current comprehensive primary care program, which serves as a patient-centered medical home program, may need to be adjusted to accommodate the role of a fiscal intermediary
- ODM may want to consider the role and methods for how a fiscal intermediary can support a shared savings program, including the complex set of provider payment rules and incentives that are used by MCOs. For example, some shared savings arrangements include a prospective per-member-per-month payment for care coordination; having a Healthcare Effectiveness Data and Information Set-based set of quality metrics; target medical loss ratio; and over- and under-utilization metrics.

## b. The advantages and disadvantages of requiring the MCOs to comply with/apply fee-for-service claims processing edits and rules. The types of edits/rules that should be determined by the MCO, including the rationale.

Our response to **Question 4b** includes our recommended solution to maximize adjudication accuracy.

### Advantages and Disadvantages of Standardized Claims Processing Edits and Rules

We recommend the use of a multi-layer code auditing technology solution to maximize adjudication accuracy. These technology applications can be structured to apply guidelines from industry-standard coding sources to analyze claims for accuracy and consistency with documented claims processing policies and procedures and national correct coding standards.

We recommend ODM adopt edits and rules to validate the provider and member before the fiscal intermediary routes the claim to the MCO for processing. We recommend the adoption of Strategic National Implementation Process level 5, as we experienced it reduces encounter errors. In the interest of timely provider notification, we also recommend the fiscal intermediary be required to reject the electronic transaction for any provider claim that does not contain the required valid data to support adjudication and encounter submission to ODM, as well as claims for ineligible members

## Claims Processing Edits and Rules Determined by the MCO

Aetna recommends ODM allow MCOs to adopt claim edit rules to validate the claim against the network provider, member, date(s) of service, service(s) rendered, and unit(s) authorized. Current MCO claims adjudication systems validate and require key data fields be provided at the claim level in order to adjudicate. These data field requirements should include but are not limited to recipient Medicaid identification number; National Provider Identifier; Provider Taxonomy Code, where required; provider ZIP code; claim type; date(s) of service; place of service/bill type; revenue codes; procedure code (Current Procedural Terminology [CPT] 4); and diagnosis code (International Classification of Diseases [ICD] 10). Examples of payment rules ODM may want to consider allowing MCOs to oversee include the following:

- **Benefits package variations:** An MCO's claims processing system should be able to automatically analyzes CPT, revenue, and Healthcare Common Procedure Coding System (HCPCS) codes to determine whether specific services are covered under the contract or under benefit rules. If a service is not covered by ODM, the system should be able to automatically deny the respective claim line with the appropriate Healthcare Insurance Portability and Accountability Act (HIPAA) remittance remark on the recipient explanation of medical benefits.
- **Data accuracy:** MCO claims processing systems should be able to continuously update our claims processing system based on current code sets (e.g., HCPCS, revenue, CPT, National Drug Code, ICD codes), so the system is always in compliance with HIPAA standards.
- **Eligibility and enrollment:** MCO claims processing systems should be able to validate the date of service against the member's enrollment segment to verify member eligibility for the date of service. If the member is not eligible, the system should be able to deny the claim and reference the appropriate HIPAA remittance comment.
- **Coding validation edits:** MCOs should have the ability to perform claims processing edits and tools to maximize adjudication accuracy. These capabilities should support front-end automation to verify correct coding and medical-policy decisions. These capabilities should also include a code-auditing solution that can apply expert industry edits from a provider-recognized knowledgebase to analyze claim accuracy and consistency against applicable policies and procedures.
- **Adherence to prior authorization requirements:** MCO claims processing systems should be able to enforce the supporting documentation requirements of certain designated services. In addition, this system, when appropriate, should be capable of configuring a prior authorization by code, provider type, and place of service.
- **Provider qualifications:** An MCO's provider files should be configured to allow for enforcement of service categories and provider type during claim validation, such as validating that certain procedures can only be performed by select network provider types. For example, systems would deny a claim for an in-office heart surgery procedure performed by a podiatrist.
- **Duplicate billing logic:** An MCO's claims processing system logic and edits should have the ability to determine duplication of services (e.g., same member, same date, same network provider, same service, or any combination of these criteria), and protect against payment of duplicate services.

**Managed Care Structure**

5. **Enrollment** — ODM intends to redistribute individuals who do not affirmatively select an MCO across all MCOs using an automatic assignment algorithm.
   a. Some states place an enrollment cap or maximum size for any individual MCO. Please share your thoughts on managing or limiting the enrollment size of MCOs.
   b. What steps should ODM take to manage care transitions to ensure the continuity of care for individuals who may be assigned to a new MCO as a result of redistributing members?

Predictability of enrollment significantly facilitates smooth, seamless implementation for a managed care organization (MCO) that is new to an area. We appreciate this opportunity from the Ohio Department of Medicaid (ODM) to offer input into this critical aspect of operations.

## a. Thoughts on managing or limiting the enrollment size of MCOs

Aetna supports the State in placing an enrollment cap or maximum size for any individual MCO to make sure the transition to a person-centered, managed care model directed toward member wellness and budget predictability for ODM is met. We recommend that ODM place an enrollment cap for any individual MCO specifically during the first contract year, thus supporting MCO and member transition. This provides all MCOs, especially new entrants, with a fair and equal chance to grow, sustain operations in this competitive marketplace, and achieve adequate enrollment to implement regionally based quality interventions.

MCOs use enrollment projections to adequately staff member-facing departments such as Care Coordination, Member Services, and crisis hotlines. If ODM places an enrollment parameters on MCOs, the MCOs have the ability to design and implement these important system resources according to the needs of the enrolled population. For example, MCOs use enrollment projections such as the number of expected children and adults with complex needs that will necessitate assignment to a care coordination program. These projections are used to determine adequate care coordination staffing ratios and appropriate qualifications (e.g., hiring licensed social workers with expertise in addressing behavioral health issues if designing a care coordination program for children with complex needs involved in multiple State and county systems). Enrollment projections are also used to determine adequate staffing ratios for other important member-facing departments such as Member Services, behavioral health crisis lines, and nurse advice lines.

MCOs must collaborate with Medicaid departments, the provider community, and community stakeholders to assess and plan for an appropriate and comprehensive provider network that is readily accessible to all unique members. Members with complex needs require access to specialty and integrated providers who can adequately address their needs. Redistributing and utilizing an enrollment cap or maximum size across all MCOs offers a balanced approach that promotes adequate system design, including design of the provider network, and promotes ODM's goal for budget predictability.

ODM's policies should allow for special circumstances such as the need for swift enrollment of population segments. MCOs must demonstrate flexibility in supporting ODM to manage changes in member enrollment as a result of a crisis or change that requires swift action. This type of flexibility is necessary to make certain member needs are met with service excellence and State-specific mission and goals are met in ever-changing Medicaid landscapes.

## b. Steps to manage care transitions to ensure the continuity of care for individuals who may be assigned to a new MCO as a result of redistributing members

Continuity of care is important for Medicaid members with complex needs who may be involved in multiple State or county systems. MCOs must make certain care transitions are managed efficiently and carefully so each member's care experience is seamless. ODM should take the following steps to manage care transitions to make sure there is continuity of care for individuals who may be assigned to a new MCO as a result of redistributing members:

- Collaborate with each MCO to make certain members with complex or special needs are readily identifiable on enrollment data or in claims history to aid in timely transition to appropriate services and resources. This may include but is not limited to children with complex needs; children involved in child welfare or multiple systems; members transitioning to waiver programs; members receiving behavioral health services; members with a serious or persistent mental illness or members enrolled in waiver programs that address mental health and substance use such as the Specialized Recovery Services program; members with acute needs such as transplant services; and/or members who are pregnant.
- Offer, at minimum, two years of encounter data/claims history
- Offer timely member notification, including a timely member appeal process when dissatisfied with continuity of care decisions
- Make certain each MCO provides uninterrupted access to covered services through ODM requirements that support sharing of existing assessments and care plans for transitions between MCOs
- Ask and enforce that incumbent and participating MCOs awarded share prior authorization data for all members prior to go-live for seamless transitions of care

We suggest the State enforce adoption of the Fast Health Interoperability Resource standards for continuity of care documents. An ODM portal would allow for timely transfer of data for a large transition as well as for regular member transition.

**Improving Wellness and Health Outcomes**

6. **Health and Wellness** — To improve health outcomes and support individual wellness, ODM will use a state-driven population health strategy designed to reduce infant mortality and preterm births, increase healthy behaviors, promote tobacco cessation, and address healthcare inequities. ODM envisions a robust community-based organization and MCO partnership infrastructure to accomplish this goal.
   a. Describe ways in which MCOs serving the same region can collaborate to create and implement strategies that have a collective impact on the population within the region with specific attention to the issues identified above (i.e., reducing infant mortality and preterm births, increasing healthy behaviors, promoting tobacco cessation, and addressing healthcare inequities).
   b. Describe how an MCO can progressively work to identify social needs and implement innovative strategies to address social determinants of health in a region including food security, housing, education, and interpersonal violence.

A statewide population health strategy led by the Ohio Department of Medicaid (ODM) involving stakeholders across the health system can effectively improve the health of the population by creating a focus on key health goals while addressing health disparities across communities. Managed care organizations (MCOs) can play a critical role in shaping and implementing the strategy.

## a. Ways in which MCOs serving the same region can collaborate to create and implement strategies that have a collective impact on the population within the region with specific attention to issues identified

Aetna recognizes and supports ODM's focus on increasing healthy behaviors and decreasing health disparities among its Medicaid population. We appreciate the partnership approach between ODM and MCOs, as working together we can ensure quality health care and collectively impact the health of Ohioans. Collaboration between ODM, MCOs, county public health departments, and other State and local agencies, along with provider groups, can have a greater impact on members within at-risk and high-risk populations. Currently, MCOs in Ohio are collaborating on quality improvement projects (QIPs) around specific initiatives such as efforts to ensure appropriate use of psychotropic medications, diabetes control, availability of healthy foods, and implementation of new assessments based on social determinants of health. Several additional areas where MCOs can work together with ODM and network providers to impact the health of the population in a region include the following:

- Statewide quality forums on targeted health topics to share knowledge and provide input for the development of state priorities and policy design, understanding trends and regional disparities, and improving communication among all stakeholders
- Task forces focused on particular State priority health areas to develop collaborative QIPs identifying shared solutions and common outcome measures, thereby having a greater impact on the health of targeted populations across the state
- Collaborative MCO and provider projects focused on prevention, intervention, and support such as targeting prenatal care access and nutritional education for pregnant women, flu shots, or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service visits
- MCOs working collaboratively with statewide organizations such as the Ohio Association of Health Plans to exchange information on trending behavioral health issues and to develop workgroups with the Ohio Council of Behavioral Health and Family Service Providers to develop innovative strategies collectively to address the needs of the membership

- Merging and simplifying of policies and processes across organizations to support providers in their participation in QIPs
- Offering integrated data systems to ensure the ability to close the loop on referrals and understand the whole-health needs of each individual member
- Gathering and sharing data such as race/ethnicity for MCO enrollees to facilitate identification of health disparities and development of strategies to address these disparities
- Encouraging and supporting the use of a health information exchange to centralize data that can be available in real time to facilitate clinical and administrative processes. This centralized resource could include non-Health Insurance Portability and Accountability Act data such as social needs and services that would reduce the time for MCO care managers and providers to identify and respond to the needs of new members.
- Having a State-managed centralized data repository to provide a resource for MCO member data that could be used to establish a road map for evidence-based and best practices
- Forming collaborations using evidence-based approaches such as the Pathways hub-and-spoke model to address topics including substance use disorders, children with serious emotional disturbance, or infant mortality—creating a local network of community organizations cooperatively addressing the needs of its community adjacent to the MCO
- Creating collaborative workgroups that include providers to develop specific strategies at the service level to impact targeted areas such as a reduction in adolescent tobacco use or increase access to prenatal care, education, and support for pregnant women

## b. How an MCO can progressively work to identify social needs and implement innovative strategies to address social determinants of health in a region including food security, housing, education, and interpersonal violence

MCOs identify social needs in a number of ways. Social information is gleaned from State health improvement plan goals and findings, regional and county organizations, and relationships with community and network providers. In addition, social needs data is collected by the MCO through standardized questions on health risk questionnaires (HRQs) used by care managers. HRQs address food security, housing stability, safety/interpersonal violence risk, loneliness, education, and employment, as well as all medical conditions, and provide one way to identify and address the social needs of individual members. Using HRQ data, MCOs can develop innovative data-driven strategies to address local needs related to social issues that impact individual health. Some of these initiatives include enhanced care coordination, non-emergency transportation, and post-hospital discharge meal delivery. Ongoing data gathering can lead to the identification of additional gaps and needs and result in collaborative quality improvement efforts to reduce health inequities.

Partnering with providers is another means by which MCOs can identify and address social needs such as working with behavioral health providers and primary care providers to screen for social determinants, such as housing and food insecurity. They share this information with MCOs for care coordination and to assist with linkage to community resources. Partnering strategies can involve MCOs incentivizing providers to screen for social determinants or sharing data with primary care practices regarding EPSDT services, which can increase the frequency of filling gaps like childhood immunizations and lead screening.

Other MCO strategies to address social needs include the following:

- Local collaborations to support General Educational Development attainment
- Home delivery of meals post-hospital discharge to reduce readmissions and improve health outcomes
- Mobile health care for preventive services such as mammograms or dental services
- Healthy behavior support tools such as offering pedometers or senior-oriented exercise and social programs

- Wellness programs to support members receiving behavioral health services
- MCO support for local health and wellness fairs
- Member texting campaigns to encourage preventive care and healthy cooking
- Collaborations with school-based health clinics addressing healthy behaviors such as reducing vaping and tobacco use, as well as mental health education for youth
- Support for community investment in affordable housing and supported housing initiatives
- Collaborations with local agencies to reduce social isolation and supportive housing needs
- Collaborations with universities to expand Project ECHO telehealth services and provide rural providers with a resource for specialty services
- Collaborations with local academic centers to expand access to innovative and evidence-based treatment options that can incorporate attention to social needs
- Collaborations with local organizations to collaborate on member care and achieve quality outcomes by creating initiatives that directly address these locally identified gaps in social services
- MCO participation at regional and local levels in stakeholder groups that include local social service funding decisions (e.g., related to affordable housing) to address the social needs of individuals more fully

A centralized data system for comprehensive data sharing would greatly facilitate the development and implementation of MCO and cross-system collaboration efforts. For example, a statewide health information exchange that includes member medical and social information could enhance the MCO's ability to identify and address members' social needs, particularly those related to health disparities, and make the MCO a strong strategic partner in the accomplishment of ODM's population health goals.

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**Improving Wellness and Health Outcomes**

7. **Performance Incentives/Reimbursement Strategies** — ODM is interested in aligning incentives and reimbursement strategies to create a health care system that improves wellness and health outcomes, while better managing financial resources.
   a. Are there specific strategies that ODM should consider to support movement along the continuum of value based care/payment models and align incentives with MCOs and provider partners to achieve greater levels of integration and improved health care outcomes? What should the MCO's role be in supporting providers in value-based payment models? Are there specific alternative payment models that ODM should consider or promote?
   b. MCO developed, value-based payment arrangements with providers that are not aligned with other MCOs may create additional administrative requirements for providers and dilute the underlying objectives. What level of discretion should ODM give to the MCOs to design their own value-based payment arrangements as opposed to requiring a more coordinated, statewide approach?
   c. ODM is considering linking incentives to outcome metrics for MCOs, providers, or both. Describe recommended processes or capabilities to collect reliable outcome measures from network providers. Please provide examples of outcome measures and how MCOs currently use that information.

Based on Aetna's experience with more than 2.3 million Medicaid members nationally, providers achieve success in adopting the Health Care Payment-Learning Action Network (HCP-LAN) alternative payment models (APMs) and by incrementally increasing their knowledge and practice of value-based reimbursement programs.

## a. Specific strategies that ODM should consider to support movement along the continuum of value based care/payment models and align incentives with MCOs and provider partners to achieve greater levels of integration and improved health care outcomes. What the MCO's role should be in supporting providers in value-based payment models. Specific alternative payment models that ODM should consider or promote.

Aetna recommends the Ohio Department of Medicaid (ODM) implement the HCP-LAN APM framework; through the managed care organizations (MCOs) experienced with APMs, ODM can improve upon a fragmented system, creating a fully integrated system of care by aligning incentives to improve health outcomes, enhancing member satisfaction, and better managing costs.

We believe that ODM plays a vital role in both leadership and direction by its commitment to fostering health care integration at the system and service level by ensuring collaboration and communication with all MCOs, providers, caregivers, and community-based organizations across the member's entire care continuum. ODM, for example, can emphasize throughout the provider community enhanced incentives for health information exchange (HIE) participation by providers to use that data for better reporting from the MCO to the provider. This data enhances providers' ability to identify gaps in care, allowing an improved 360-degree clinical view of the member and their quality outcomes. Through periodic interaction with providers collaborating with us on value-based payment (VBP), we assist them in building population health infrastructure such as integration with the HIEs in Ohio or enhanced electronic health records (EHRs). We recommend that ODM advocate and support use of Current Procedural

Terminology (CPT) Category 2 codes that will improve calculation of incentives and could reduce provider administrative burden for determining member outcomes. We believe CPT Category 2 codes can help address provider pain points in collaborating and developing creative solutions, including HIE/EHRs; these and others will be on the table for discussion. ODM and MCOs can jointly support transitioning providers by educating them along the continuum of VBP models. We also recommend MCOs collaborate with providers through periodic interactions to make certain providers receive education, information, and oversight to create the best possible VBP solutions.

Transitioning to VBP arrangements can be difficult for providers, particularly for specialists and behavioral health (BH) providers. For some practices, VBPs may create administrative and operational challenges that can seem daunting and overwhelming. To mitigate these challenges, we further recommend that ODM consider VBP programming from an agency level within the framework of the HCP-LAN APM model, which allows ODM to introduce all important stakeholders such as community organizations, professional associations, and caregivers to incentivized quality improvement in care coordination as directed in the HCP-LAN APM framework. Doing so, we believe, will allow both ODM and the health care delivery system to lead members to living healthy, vibrant lives central to bringing about transformation of the system of care.

VBP and APM strategies are important elements in promoting and achieving integrated models of care. We recommend ODM implement a multitiered and appropriately paced implementation of VBP with MCOs that support providers. VBP should be built on concepts of collaboration, assessment of provider readiness, and support to minimize disruption and risks. VBP strategy should focus heavily on improvements in clinical outcomes and access to services, as this has proven effects on total costs of care and provider and member satisfaction. ODM should also emphasize mechanisms that support integration of physical health (PH) and BH care, incorporating the social determinants of health and bending the cost curve, including the following:

- Data analytics/provider detailing to share patient information regarding quality metrics and service utilization that aid our providers in making good health happen for their patients
- Primary care integration of BH screening to better coordinate member care
- Integration of health risk assessment and scale-based interventions into clinical practices and settings that assist providers in improving care outcomes
- Enhanced treatment access through creative solutions such as telemedicine
- Programs and incentives that support analytics, data assessment, and smart reporting, putting real-time information into providers' hands for improved BH/PH integration

## b. The level of discretion ODM should give to the MCOs to design their own value-based payment arrangements as opposed to requiring a more coordinated, statewide approach

States and MCOs pursuing APMs have the shared goal of improving health care value, while reducing the cost of care and transforming health care from a system based on volume to one that incents value.

Aetna recommends ODM adopt the HCP-LAN APM framework as a value-based continuum and work with MCOs to enable and ensure the transformation of a fragmented care delivery system. The framework would effectively accommodate independent provider needs while allowing each MCO the autonomy to maximize the use of technology, health care assessments, risk assessments, and use of data analytics to create APMs such as those that address disease state that have the greatest impact on costs. We recommend transparency among MCOs for respective outcome measures used in conjunction with those provider incentive APMs to create administrative and reporting efficiency for providers in their use of outcome measures.

## c. Recommended processes or capabilities to collect reliable outcome measures from network providers. Examples of outcome measures and how MCOs currently use that information.

We believe a focus on core Healthcare Effectiveness Data and Information Set (HEDIS) outcome measures tied to VBP incentives creates effective, streamlined goals for providers to achieve positive outcomes for members. By focusing provider incentives on a select number of HEDIS measures that have financial implications, ODM can create a consistent approach for our provider partners limiting administrative deficiencies. Through claims and data mining analysis of HEDIS outcomes, MCOs target members who need care by determining, in part, which members have missing clinical tests or immunizations. We recommend ODM identify measures that best help MCOs and providers target outcome measures that best identify these gaps in care. We also recommend creating a menu of VBP-related HEDIS measures from which providers can choose to customize their approach to achieving quality outcomes dependent upon the needs of their unique patient populations, including some of the more commonly noted measures as follows:

- Childhood immunization status
- Well-child exam ages 3, 4, 5, and 6
- Timeliness of prenatal care
- Use of multiple concurrent antipsychotics in children and adolescents
- Comprehensive diabetes care (HbA1c testing)
- Potentially avoidable use of emergency departments

As providers gain their footing and expertise in VBP arrangements MCOs can help to expand their focus to additional HEDIS measures to have a greater and deeper impact on member wellness. Through periodic interactions with provider practices, MCOs can help them track HEDIS measure progress and reporting with in-depth consultation and assistance to achieve optimal results. This aligns with the HCP-LAN goal of making appropriate care measures a requirement for Category 3 and 4 APMs to give providers strong incentives to focus on creating greater efficiency in bending the cost curve and maximizing finite state Medicaid health care financing. Streamlining measures also addresses the HCP-LAN framework's effort to identify opportunities that expedite and simplify the progress-tracking effort.

We recommend that ODM foster collaboration between MCOs and providers to add measures over time to aid providers to meet their needs in risk arrangements and other APMs through customized solutions to address their pain points and meet their member outcome needs.

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**Improving Wellness and Health Outcomes**

**8. Quality Improvement –**

a. For entities that have experience in population health approaches, describe the tools and processes that were used to achieve population-level improvements. Describe dedicated staff composition and/or training required to manage these efforts, highlighting areas of success and partners crucial to that success. How might the improvements and lessons learned be integrated into MCO operations?

b. How can MCOs support better population health management and constant quality improvement at the health-system level? How might those efforts be aligned with the State to maximize collective impact?

Aetna believes managed care organizations (MCOs) should develop population health strategies that analyze population-level data through a personalized lens to create initiatives and practices that empower members to achieve their health goals.

## a. Tools and processes used to achieve population-level improvements. Dedicated staff composition and/or training required to manage these efforts, highlighting areas of success and partners crucial to that success. How improvements and lessons learned might be integrated into MCO operations.

With a focus on equity, data, and evidence-driven strategies, MCOs should ensure convenient and easy-to-access resources that are targeted to meet the needs of the populations. All programs should be closely coordinated so all benefits and resources can be accessed regardless of point of access, cultural orientation, health literacy, preferred language, or social determinants of health (SDOH) factors that impact accessibility. Population health program design should follow from a locally rooted understanding of population health priorities, needs, and assets while having the underpinnings of a national structure driven by population data analytics and evidence-based practices that focus activities for distinct member populations throughout the continuum of care.

### Population Health Tools and Processes

An MCO's population health approach to achieve population-level improvements in Ohio should begin with a comprehensive needs assessment of members that is reviewed and revised annually. The needs assessment should be accompanied by a risk stratification process and the resulting alignment of members categorized in each segment of the population within a population health model established at the MCO. As members are stratified, MCOs can identify their conditions, diagnoses, risk for future emergency department visits or inpatient admissions, and gaps in care. MCOs should distribute resources to members based on characteristics identified through the needs assessment, factors that influence the stratification level, and subsequent individual level assessments. MCO tools for assessments and analyses completed at the population and individual level could include the following:

- Member health risk appraisal
- State Health Improvement Plan (SHIP)
- Care management comprehensive and focused assessments and questionnaires
- Membership/population profile analysis
- Health care equity dashboard reporting
- Community health needs assessment using CommunityCommons.org and/or market regional health profiles
- Federal/state/county/municipal/community population health surveys and assessments

Using the assessment and analysis tools, the population health approach processes should include aligning care management service-level provision with the stratified risk level from low risk (monitoring) to high risk (complex care management). MCOs should additionally use tools and processes that support the population health management strategy which are not direct member interventions, including the following:

- Information sharing with individual practitioners
- Technology support and integrating with value-based payment (VBP) arrangements/population health integrated care model
- Integration with community resources

### Dedicated Staff Composition and Training

A successful Population Health Management team should include administrative and clinical support at the MCO level, as well as staff embedded in the communities in which they live including care managers, care manager assistants, registered nurses, social workers, licensed independent social workers, licensed professional clinical counselors, community health workers, and peer support specialists. In addition to formal training, we recommend population health management staff be fully educated on the State goals as established by the Ohio SHIP, and the specific needs of identified populations regionally and statewide.

### Collaborations Crucial to Achieving Population-level Improvements

MCO collaboration with federal, state, and community organizations is critical to the success of a population health program to achieve population-level improvements. All involved stakeholders need to be working toward the same goals as identified in the SHIP to leverage and maximize resources and efficiencies. In Ohio, crucial collaborators could include the following:

- Providers, especially those utilizing VBP arrangements
- Community-based organizations that address SDOH, including housing providers, food banks, youth service providers, and faith-based entities
- Federally qualified health centers and community mental health centers
- Medical societies and provider associations
- Universities and local schools
- State agencies

### Integrating Improvements and Lessons Learned into MCO Operations

MCOs can integrate these improvements and lessons learned into a continuous quality improvement strategy through their quality management oversight and processes. MCOs should measure, analyze, and track performance indicators that reflect the Ohio Department of Medicaid's (ODM) population health focus, including population streams (e.g., women's health, chronic conditions, and behavioral health), VBP strategies (e.g., comprehensive primary care, episode-based payments), and health equity focus.

## b. How MCOs can support better population health management and constant quality improvement at the health-system level. How those efforts might be aligned with the State to maximize collective impact.

Constant quality improvement at the health system level requires close collaboration between all MCOs with ODM and other critical social service agencies. Efforts should be closely coordinated and shared to leverage and maximize resources to holistically address need and to promote the best health outcomes possible for members.

## Constant Population Health Management Quality Improvement at the Health-System Level

MCOs can support better population health management and constant quality improvement at the health-system level through data sharing and exchange in as near real-time as possible to allow for robust analysis of the population; ODM and MCOs could promote, utilize, and leverage the information within the health information exchange (HIE). Currently, each MCO needs to separately negotiate a contract with the HIE, and in some cases, negotiate with individual providers to have access to their data. Not all organizations are using the HIE, especially in the rural areas where the data gathering for constant quality improvement is critical.

The HIE data, aggregated with the MCO data, would enable MCOs to conduct in-depth population health assessments, including examination of county and ZIP code level analysis, differences in National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set measures, and service-level utilization to identify and resolve gaps in care. MCOs could use this data to identify groups of members to target for interventions, with staff outreaching and engaging members into care including community health workers, peer support specialists, and Care Management staff.

## Aligning Population Health Management Efforts with the State to Maximize Collective Impact

MCOs can align population health management quality improvement efforts with NCQA's population health management model and standards and Ohio's State Health Assessment and SHIP to maximize collective impact. This alignment of the population health management efforts across MCOs would allow for identification of gaps and development of priorities, including children's health, preterm birth, premature death, unintentional injuries (including drug overdose), cancer, heart disease, and disparities within several groups, including Ohioans who are black/African-American and individuals who live in Appalachian counties. Using this information, MCOs can work together to collaborate on performance improvement projects across the state, leveraging providers and organizations at the local level to maximize health outcomes.

To facilitate this, ODM could consider sharing statewide data with MCOs to target initiatives as well as requiring providers to participate in initiatives through the credentialing process and contract specifications to ensure their participation in maximizing the collective impact.

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**Improving Wellness and Health Outcomes**

9. **Employment, Education and Training** – Poverty, food insecurity, housing, and employment status can impact an individual's overall health. Under an 1115 waiver application approved by the federal Centers for Medicare and Medicaid Services, individuals enrolled through Ohio's Medicaid expansion (Group VIII) will be required to demonstrate they work 20 hours per week or are engaged in other allowable activities, including job search, education and training, or community service.
   a. Describe ways in which an MCO can support work-ready individuals to seek and retain employment.
   b. Describe successful approaches and/or programs designed to educate or train individuals for future potential employment opportunities (e.g., through MCO- sponsored programs, connections with vocational education or other higher education institutions).

Lack of access to employment, education, and training opportunities can impact a member's overall health. In many cases, additional social determinants, such as housing instability, lower levels of education and health literacy, lack of transportation, underemployment, food insecurity, or a difficult home environment can also serve as a root cause of poor health, contributing to health care under- and over-utilization and resulting in poor health outcomes. Aetna understands that the Ohio Department of Medicaid (ODM) , under their 1115 waiver application, will require those who enroll through Ohio's Medicaid expansion to demonstrate they work at least 20 hours a week or are engaged in other activities, such as job searches, education, and training.

## a. Ways an MCO can Support Work-ready Individuals to Seek and Retain Employment

As a managed care organization (MCO), Aetna offers employment support and workforce development programs to engage members and help them achieve training, education, and vocational goals. We also use State and local resources to provide linkages to job opportunities in our members' communities. A strong collaboration between MCOs and ODM on this initiative will lead to greater long-term success and a more financially stable Ohio Medicaid system. Based upon our multistate experience and the vast resources of our national organization, we would propose MCOs be encouraged to use a variety of successful programs to assist work-ready individuals in Ohio. Examples include the following:

- Developing relationships with local community colleges, universities, and other educational institutions to provide opportunities for members to develop skills for high-demand jobs, such as personal care aides and community health workers
- Collaborating with OhioMeansJobs to recruit displaced workers and veterans for direct hire positions, providing job skills and interviewing and assessment training, as well as hosting numerous hiring events
- Engaging members in peer-based or community-based networking opportunities
- Offering training and information across multiple channels, including mobile, web, texting, newsletters, and kiosks
- Building connections to community-based education/employment resources
- Providing specific benefits and services that address barriers, such as housing, transportation, childcare, or help caring for older adults who may live in the member's home and rely on the member's caregiving services
- Mining national organizations that serve different segments of the population and different age groups for possible linkages

- Collaborating with local community- and faith-based organizations to arrange job externships, assisting members with interview attire and preparation, and creating ways to access employment opportunities

## b. Successful Approaches to Educate/Train Individuals for Future Potential Employment

Aetna believes it is within the MCO's role to invest in program partnerships in the communities served to enhance education and training opportunities for members. Customized program partnerships with local community colleges and universities aimed at training individuals to meet high-demand jobs as discussed under **Question 9a** is a key ingredient. In addition to specialized, locally based training, there are other approaches to education and training programs that can be provided by MCOs, including the following:

- Facilitating on-the-job training opportunities, volunteer opportunities/public service that build skills to include on a resume, as well as any participation in community-based education/training
- Developing/offering clinical experience internships to help members gain a foothold into successful employment
- Offering summer internship programs for youth
- Offering workforce training initiatives that teach entry-level skills in targeted, high-demand jobs
- Engaging with the U.S. Department of Labor apprenticeships, when available
- Establishing a job shadowing program with timeframes, goals, and results and a plan of how a member can refine that experience into full- or part-time employment
- Addressing under-prepared/under-educated members by offering test preparation and testing for the General Education Development degree

**Improving Wellness and Health Outcomes**

**10. Dental Services** — Stakeholders throughout the State identified the importance of dental services to ensuring improved health outcomes. Describe successful approaches, from Ohio and other states, for increasing access to dental services, including access to specialty dental services, particularly where there are network gaps, such as rural areas.

We recommend a multipronged approach to increasing access to dental services that includes offering value-added dental benefits and incentives; using a centralized dental vendor for administrative and mobile dentistry functions; completing outreach activities that promote dental appointment attendance; and where possible, offering transportation to and from dental appointments.

For managed care organizations (MCOs) that collaborate with a dental vendor, the vendor can provide customized assistance to MCO Clinical Care Coordination staff to accurately identify individual member dental needs and locate appropriate providers. Care coordinators and members can collaboratively reach out to our dental vendor, which offers triage of the member's clinical circumstances and assists in locating a suitable provider.

MCOs can initiate member engagement activities that promote and educate members about the benefits of routine dental care such as community events, school-based events, and health fairs. MCOs can also facilitate member outreach activities that support preventive or routine appointment attendance. They can pull reports on members who have missed appointments and provide member outreach such as mailing a letter or making an outbound telephone call to remind members to reschedule or attend their appointments. Where possible, MCOs can offer no-cost transportation to-and-from dental appointments for members who lack reliable transportation, supporting members with keeping appointments.

MCOs can support and promote increasing access to specialty dental services particularly in areas where there are network gaps or in rural areas by authorizing certain specialty dental services, using single-case agreements (SCAs), and collaborating with community stakeholders to facilitate mobile dental screening services in rural areas. When necessary for members, MCOs should be encouraged to utilize SCAs with providers who are geographically available to members but not in the MCO network. This strategy can be successful in giving certain members access to specialty services when medically necessary, such as oral dental surgeons. MCOs may be able to successfully collaborate with community stakeholders to facilitate mobile dental screening services in areas where there are network gaps and rural areas. MCOs should collaborate with the Ohio Department of Medicaid to identify how additional initiatives such as having school-based health centers or mobile services in identified schools could be a springboard for engaging families about the benefits of preventive dental care and educating families about their options for accessing care.

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**Improving Wellness and Health Outcomes**

**11. Transportation —** Describe how MCOs could improve the provision of non-emergency transportation to individuals (e.g., the quality and safety of drivers and vehicles, reducing wait and transport time, real-time monitoring, allowing siblings, providing same-day transportation, and allowing multi-stop transport), including recommendations specific to improving access in rural areas (e.g., expanding the number of qualified drivers or using ride-sharing services).

Aetna acknowledges that non-emergency transportation is a serious concern among individuals and advocates involved with the Ohio Medicaid managed care program. The issue is a stakeholders' feedback theme in **Request for Information (RFI) No. 2** based on responses to **RFI No. 1** and the 19 listening sessions around the state. This RFI identifies transportation challenges as "significant," stating they "impede individuals' ability to access services (e.g., difficulty accessing timely rides, no shows, late pick-ups, poor customer service)."

## Improving the Provision of Non-emergency Transportation to Individuals

Managed care organizations (MCOs) could improve the provision of non-emergency transportation to individuals in rural, urban, and suburban areas of Ohio by implementing a service model that includes the following components:

- Utilizing rideshare services
- Collaborating with community-based organizations
- Providing value-added benefits
- Offering fuel-cost reimbursement

### Utilizing Rideshare Services

Contracting with rideshare vendors could be a viable alternative to transportation barriers. **One rideshare vendor, for example, announced in January 2019 its services are available to the entire state of Ohio, enhancing access to individuals in rural areas.** Ridesharing is accessible and predictable and can provide a positive member and provider experience. Rideshare services share each driver's rating with the consumer, which aligns with improving the quality and safety of drivers and vehicles. Members are less likely to miss appointments because they do not have a ride and providers experience lower no-show rates. Rideshare services applications allow for real-time monitoring by the member and provide a predicted time of arrival to the destination. According to mHealth Intelligence, no-show rates range from 10 to 30 percent nationwide.[1] In a 2018 study by Lyft and Hitch Health at Minneapolis Hennepin Healthcare, in one year at a downtown clinic, a ridesharing service helped reduce no-shows by 27 percent.[2]

Rideshare options also could alleviate pain points for the Ohio Department of Medicaid (ODM) and MCOs around **allowing siblings to accompany** a member during a ride. This means that a caregiver would not be torn between accompanying a child to a medical appointment or missing the appointment due to lack of childcare for the other sibling(s). The rideshare driver could also provide car/booster seats for all children on the ride. Additionally, and when properly contracted, **same-day transportation** and **multi-stop transport** are also possibilities and are achievable as we move along the continuum of this growing vendor industry.

[1] "Ridesharing Services Help mHealth Programs Improve Care Coordination," accessed February 22, 2020; https://mhealthintelligence.com/features/ridesharing-services-help-mhealth-programs-improve-care-coordination
[2] Ibid

## Collaborating with Community-based Organizations

MCOs collaborate with community-based organizations and local agencies in all five regions of the state to provide a variety of services for members, including non-emergency transportation. The MCOs' care managers work with the members and these organizations to schedule and coordinate medical appointments and transportation services. **These services are especially important in rural areas like southeast Ohio, where there are fewer providers and access to care is more challenging.**

## Providing Value-added Benefits

MCOs have an opportunity to improve the provision of non-emergency transportation to individuals and families by offering value-added benefits. These benefits can provide members additional opportunities to make scheduled trips with a transportation vendor as well as expand the scope of service to address their whole-person needs.

## Offering Fuel-cost Reimbursement

Travel reimbursement could enable family members or friends to provide additional transportation options for members. Absent reimbursement for fuel costs, a members' supports might find it cost-prohibitive to drive members to their appointments, **particularly in rural areas where members might have to travel greater distances for access to their providers.**

In summation, the options described in this response could expand transportation opportunities from traditional transport to rideshare, and eventually to on-demand transportation. This would create a continuum of services and a more **member-driven transportation benefit.** The member, if they are willing, would have the ability and choice to decide what transportation alternative best meets their personalized needs.

## Additional Consideration

ODM might consider broadening the transportation benefit to include additional services (once approved by a provider) that a member needs to improve their health. Such transportation might include visits to a chiropractor, physical therapist, or a pharmacy, among others. This would better ensure members receive greater continuity of services in a timely fashion.

**Improving Care for Children and Adults with Complex Needs**

12. Care Coordination — Improving the continuum of care coordination opportunities for all individuals is critically important to ODM. Currently, MCO care coordination is largely separate from or loosely connected to community-based care coordination structures, and individuals and providers report difficulty in navigating MCOs' internal departments and processes. Going forward, ODM's approach to care coordination for individuals enrolled in the managed care model will emphasize respect for individual care preferences, drawing on the care coordination capacity that exists in communities, and offering time-limited MCO problem-solving capabilities to individuals and providers.

    As a default, individuals enrolled in existing care coordination structures through ODM-designated types of Care Coordinating Entities (e.g. County Boards of Developmental Disabilities, PASSPORT Administrative Agencies, and possibly others) will receive comprehensive coordination through these community-based structures. When these ODM-designated care coordinating entities (CCEs) are designated as primary care coordinators, the MCO will serve in a supportive role by providing both systemic support to the CCE, as well as personalized assistance to community care coordinators as they work to meet individuals' needs. ODM envisions a highly collaborative model that expeditiously and seamlessly connects individuals to quality services.

    The MCO will also be responsible for fulfilling care coordination responsibilities for individuals who need ongoing care management, but who are not actively engaged in coordination through CCEs, who choose to receive care coordination through the MCO, and/or who live in an area in which a Care Coordination Entity is not available.

    Additionally, ODM is interested in having MCOs offer "Care Guide" services to all enrolled members and their providers to address short-term needs. Care Guides' time- limited engagement would require problem solving that bridges MCO departments to assist with filling immediate/acute gaps in care and access, remove administrative barriers, refer to organizations that can address social determinants of health, assist with appeals/grievances, and connect individuals with longer-term community-based or MCO care management services when appropriate. Care Guides would be responsible for closing referral loops and tracking cases until resolution is reached or a warm handoff is made to a longer-term solution.

    ODM seeks input on the following:

    a. In the MCO and CCE model explained above, describe the roles, responsibilities and collaboration among involved entities that will be needed to ensure care access and continuity of care for individuals transitioning between tiers, transitioning between settings and transitioning between MCOs and/or CCEs when necessary. How should roles and responsibilities be delineated to leverage strengths of MCOs and community-based CCEs? How can duplication of effort be minimized across the entities?
    b. Which types of community-based CCEs should be considered for ODM designation? How might MCO systemic support to CCEs vary by the type of entity designated as a CCE? (E.g. what MCO systemic supports are needed for waiver service coordinators, for specialized recovery services[1] care management agencies, for comprehensive primary care practices?)
    c. In working with a community-based CCE and its care coordinators, what could the MCO do to support individual care needs and remove barriers to support the timely delivery of services? What is the best way for ODM to measure MCO support and responsiveness?

d. How could MCOs and CCEs meaningfully exchange data and information to improve care outcomes? What types of data and information should be exchanged?
e. What suggestions do you have for care coordination staffing and qualifications, taking into account both quality and administrative expense? How could alternative staffing arrangements (i.e. team-based care requirements, hub-and- spoke models, etc.) be used to efficiently meet individuals' care management needs?
f. What recommendations and best practices might help ODM monitor the ongoing quality of care coordination/case management? What approaches could be used to effectively and efficiently monitor performance of both individual care management/care coordination outcomes, and outcomes for the care coordination/care management program as a whole?
g. What types of structures and processes should be put in place to ensure Care Guides can quickly and effectively meet each individual's time-limited needs? How could ODM monitor the quality and effectiveness of the Care Guide program?
h. How could each type of care coordination role (MCO, community-based CCE, Care Guide) assist individuals with addressing health-related social needs?

The future Medicaid managed care system must build on the existing strengths of the current system to address the critical health issues Ohioans face today such as high rates of infant mortality, deaths due to overdose, and increase of children involved in public service children's agencies due to the opioid epidemic.[2] As key partners in the health care system, managed care organizations (MCOs) have a role in addressing these issues by ensuring effective coordination of care through facilitating seamless transitions between care settings, personalized care, transparent communication and accountability, provider support that drives better patient care, and fully integrated data sharing. The care coordination approach for children and adults with complex needs should include MCOs with proven, comprehensive care coordination outcomes; customized, managed care structures that emphasize respect for individual care preferences; and demonstrated capability to collaborate with community-based organizations.

## a. Approaches that Ensure Access to and Continuity of Care

The approach described by ODM is customized to meet the State's goals of increased access to and coordination of integrated services, improved communication among stakeholders, and seamless continuity of care to meet changing needs. Delineation of roles and responsibilities is key to strong, effective collaboration between partners within the health care delivery system.

### Roles, responsibilities, and collaboration among involved entities that will be needed to ensure care access and continuity of care for individuals transitioning between tiers, transitioning between settings, and transitioning between MCOs and/or CCEs when necessary

In our experience, having clearly defined roles and responsibilities across the entities involved in making sure members have care access and continuity of care is critical for member success and satisfaction. This should include clearly defined processes and managed care support for members who transition between settings. The MCO's roles and responsibilities include collaboratively implementing and maintaining managed care structures that support care access and continuity of care, including the following:

[1] Ohio's specialized recovery services program is jointly administered by ODM and the Ohio Department of Mental Health and Addiction Services to provide home- and community-based services to individuals with qualifying diagnoses of severe and persistent mental illness or diagnosed chronic conditions in accordance with Chapter 5160-43 of the Ohio Administrative Code.
[2] The Ohio Department of Medicaid (ODM), "The ODM Annual Report August 1, 2019": accessed February 2020; https://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/ODM-Annual-Report-SFY19.pdf.

- Promoting and offering care coordination entities (CCEs) support on using person-centered, integrated, holistic care coordination approaches built on community strengths; care coordinators should be regionally based in local community settings and specialized to meet the unique needs of members
- Offering readily accessible, member-facing resources that support CCEs' success such as 24/7/365 member services, behavioral health crisis, and nurse advice lines, and web-based or smartphone resources that offer accessible resources such as member identification cards, primary care provider contact information, or text messaging with an assigned care coordinator
- Enforcing and promoting member rights through MCO-operated complaint, grievance, and appeals systems that strictly adhere to regulations and promote member satisfaction
- Offering technology solutions that promote real-time data-sharing with the member, guardian, providers, care planning team, and other involved stakeholders
- Making certain there is a comprehensive provider network that meets the needs of the population and is focused on quality-driven performance based on outcomes
- Customizing system and health plan staffing toward the unique needs of the population served; examples include having a clinical pharmacist or pharmacy director for coordination with a carved-out pharmacy benefits administrator or having a dedicated liaison for children who makes certain there is cross-sector communication and collaboration for children involved in public service children's agencies
- Enforcing service excellence and quality-driven standards through Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), national accreditation such as the National Committee for Quality Assurance, and/or other avenues that support member satisfaction and member success
- Offering support and technical assistance that promotes population health strategies including population health reporting, training and technical assistance for providers, and meaningful data tracking on member referrals

When designated as primary care coordinators, the CCE's role includes functioning as the single point of contact for member care, acting as the centralized source for member assessment and care plan information, engaging the MCO, providers, care team, county agency case workers, and involved community stakeholders in care planning meetings, sharing and communicating member updates, linking members to needed services and resources, and removing barriers that impact care access and continuity of care. When designated as primary care coordinators, the CCE's responsibilities include the following:

- Completing initial and ongoing assessments in a timely manner, per State requirements, or as often as members' needs and circumstances change
- Facilitating care planning meetings that involve the member, guardians, their circle of support, providers, county agency case workers and/or guardians, involved community stakeholders, and other staff as necessary
- Documenting member assessment, care plan, intervention, and updates
- Sharing member and documented information with the care team timely and as appropriate
- Maintaining regular, ongoing communication with county case workers, the member, guardians, care team participants, and other involved stakeholders

The MCO's role for members transitioning between tiers, settings, or MCOs is to make certain there are clearly defined processes and communication methods that support member continuity of care at the system level. This includes identifying members with complex needs at the time of enrollment, making sure the provision of services is uninterrupted, not denying services during transitional periods, and monitoring the quality of care. MCOs should consider how the health plan is staffed to support collaboration and communication. As an example, Aetna offers System of Care administrative staff in other Medicaid markets that serve children and adults with complex needs and are dedicated to making

certain the larger health care system functions effectively. The MCO further supports continuity of care during transitions by offering the CCE team round-the-clock member support that includes 24/7/365 member services and crisis hotlines, and accessible, easy-to-use web-based resources such as a secure member portal and smartphone mobile applications. MCOs should make certain member-facing department documentation systems are integrated and that there are written policies requiring two-way communication. For example, if a member contacts the MCO Member Services department with questions about a care coordination program, the Member Services representative would answer any questions and then warm transfer the member using three-way conference calling to the CCE, securing connection to the program and making sure all questions are sufficiently addressed. For all member interactions, the CCE staff would review notes from any MCO member-facing department in the shared documentation system.

The CCE's role for members transitioning between tiers, settings, or MCOs is to be aware in near real-time of all member transitions, assessing ongoing member care needs, initiating and maintaining active communication with involved parties, and facilitating and monitoring continuity of care. This would occur through daily member and care team interactions by gathering information; communicating via telephone, email, or text; reviewing documentation; completing telephonic and in-person visits and reassessments; addressing and removing barriers to care access; collaboratively problem-solving member issues with the care team or MCO staff; making certain care planning participants have the most up-to-date member assessment and care plan information; and engaging care planning team participants in a meeting when members experience an acute change in circumstances.

### How roles and responsibilities should be delineated to leverage strengths of MCOs and community-based CCEs

The MCO should work collaboratively with ODM and CCEs at the onset of contract award and continuously thereafter to leverage strengths. This should occur through regular meetings where the goal is understanding each entity's role, responsibilities, functions, strengths, and areas for improvement or risks. MCOs and CCEs would then collaboratively decide roles and responsibilities based on assessment of strengths, areas for improvement, and risks. The benefits of a model based on leveraging strengths includes a unified approach to integrated health care that promotes quality service, building behavioral health competencies in physical health entities, unified data management that supports near, real-time decision-making, and enhanced involvement of member primary care providers.

### How duplication of effort can be minimized across the entities

Duplication of effort can be minimized through using a designated single point of contact for care coordination (in this model, the CCEs are the primary care coordination entities), utilizing a holistic, integrated care coordination approach, making certain there is transparent, cross-sector communication and collaboration that leverages strengths, and using an electronic documentation system that operates as the single source of information for member care.

## b. Community-Based Care Coordinating Entities

Common qualities that characterize effective care coordination entities can be considered when developing a care coordination approach within the broader health care delivery system.

### Types of community-based CCEs should be considered for ODM designation

Aetna supports and promotes collaborative care coordination models built on the existing strengths of the community. Successful care coordination models have specific operational elements that increase the likelihood the model is effective, efficient, and member-focused. This includes making certain there is adequate staffing, supervision, and training resources, ability to monitor subcontractor performance, and technological capabilities for documenting and sharing member information.

In our experience, CCEs need to have existing operational structures to effectively implement and maintain a community-based, care coordination staffing model. This includes resources for hiring, training, and supervising Care Coordination staff who have licensure or specialized expertise such as registered nurses, licensed social workers or counselors, licensed substance abuse counselors, or peer support staff. CCEs need resources to facilitate initial and ongoing training that is reflective of the desired care coordination approach and required staff skills and ODM requirements. This includes completing assessments, facilitating care planning, practicing cultural competency, and meeting the unique needs of the population.

Supervising care coordinators is a critical factor in program success. Care coordinators need access to licensed supervisors experienced in care coordination approaches, case staffing, children and adults with complex needs, children involved in multiple systems of care, team-based problem solving, and removing barriers to care. In an integrated model of care, this should include supervisors who are experts in a variety of specialties such as nursing, behavioral health, substance use, pharmacy, medicine, and peer support.

Agencies and practices designated as CCEs need the ability to drive systemic improvement and enhance outcomes for members through performance oversight activities including performance by any subcontracted vendors (e.g., an interpreter service). Monitoring care coordination performance includes having access to resources such as a quality department, data or business analysts, or staff who can track, trend, and monitor care coordination data. It also includes having access to reporting tools that allow for accurate, timely reporting of care coordination activities. Reporting tools should include two-way mechanisms for communication and be designed to monitor and trend individual and program-level care coordination activities.

Agencies and practices designated as CCEs need the technological capabilities for documenting and sharing member information. In managed care systems that serve children and adults with complex needs, there are often multiple systems, agencies, providers, and stakeholders involved in each member's care, each with their own information system for documenting member interaction. The use of an electronic documentation system that acts as the single source of truth for member care is the most effective and efficient design for near real-time coordination. When multiple information systems are involved that are not integrated, the result is often a breakdown in cross-sector communication, duplication of efforts, and fragmented care for members. The electronic documentation system should include data integration with county- and State-level agencies, providers, and stakeholders such as health information networks, offering the ability to share data in near real time that is critical to effective care coordination.

Our recommendation is that ODM consider whether each CCE has the elements necessary for building and maintaining a successful community-based care coordination system as listed. Utilizing a readiness and/or capability assessment tool that captures necessary elements may help ODM gather information and determine each agency's ability to function effectively as a CCE.

### How MCO systemic support to CCEs may vary by the type of entity designated as a CCE

The type of systemic support needed from the MCO will depend on the structure, size, and capability of the designated CCE. For example, SRS care coordinators are likely experts on substance use, member engagement, and the use of peer support services but may need MCO support on training topics and programs that address resources for physical health needs and chronic diseases. Care coordinators working at CPC are likely experts on physical health and medical needs but may need training and technical assistance on using behavioral health or substance use screening and assessment tools such as the Screening, Brief Intervention and Referral to Treatment for patients exhibiting substance misuse or the Patient Health Questionnaire-2 for patients exhibiting depression.

## c. Support for Individual Care Needs and Timely Services

Ensuring person-centered care and timely access to services are among the central responsibilities of MCOs.

### What the MCO could do to support individual care needs and remove barriers to support the timely delivery of services

Based on our experience, we recommend that MCOs offer the following types of support to make certain individual care needs are met and barriers to care are removed, resulting in timely delivery of services:

- Initial and ongoing training that includes training on person-centered, integrated, holistic approaches, cultural competency, health disparities, trauma-informed care, and the unique needs of the population served
- Timely access to problem-solving resources such as Utilization Management staff, system experts, and medical directors
- MCO governance structure that supports effective systemic functioning and results in enhanced care access for members
- Access to Utilization Management staff and online resources for service requests that require prior or continued authorization; MCOs should facilitate regular review, and where necessary, change of authorization guidelines based on population needs through Joint Operating Committees
- Member and Family Advisory Committees that elicit feedback directly from members, parents, guardians, and stakeholders; MCOs must make certain there are mechanisms that incorporate member and family feedback into MCO policies and/or training
- Value-based contracting solutions that promote and incentivize quality-driven outcomes
- Population health strategies and resources that link all members, including members who do not require care coordination to community resources
- Round-the-clock, 24/7/365 access to member-facing departments such as Member Services, Behavioral Health, and nurse advice hotlines
- Value-added benefits and services that promote access to care such as benefits for dental or transportation services
- Dedicated health plan staff that address systemwide functioning and remove barriers that negatively impact care access
- Departments that support and promote member rights
- Comprehensive, integrated provider network that includes providers with extended hours

### The best way for ODM to measure MCO support and responsiveness

In response to the best way for the ODM to measure MCO support and responsiveness, we recommend mechanisms that measure performance for the functions described in the previous section. For example, MCOs can provide reports on the percent of providers in value-based contracting that include detail about the type of contract and membership. ODM could hold regular meetings with MCO health plan staff designated to oversee care coordination outcomes including administrators responsible for system functioning. ODM should make certain each MCO provider network is adequate to support member needs and could look for MCO networks that emphasize best practices for the population served and/or most improved providers.

## d. Meaningful Data Exchange that Improves Care Outcomes

System partners must have meaningful data exchange mechanisms in place for real-time coordination and weekly, monthly, or quarterly reporting to collaboratively improve care outcomes.

### How MCOs and CCEs could meaningfully exchange data and information to improve care outcomes

Based on our experience, we recommend the use of technology that supports near real-time sharing of member information and use of an electronic care management documentation system that can be accessed by all involved entities, including MCOs and CCEs. The system works best when it operates as a single source of truth offering members, guardians, providers, county case workers, and other involved parties' access to information when needed. Ideally, this system is integrated with MCO departments such as Utilization Management, Member Services, and crisis hotlines, and care coordinators can view documentation by other departments and then act on that information on behalf of their designated members. Members, guardians, and the member's caretakers or circle of support should also have access to this system to view their member information readily and easily from our secure member portal located on our website or when logged into their smartphone mobile application.

MCOs should have data integration capabilities and an ongoing data integration strategy that includes collaboration with existing State and county systems such as State-specific health information exchange networks, public service children's agencies information system, and Medicaid department available data. Integrating data supports accurate and timely enrollment processes, aligns members with the appropriate intensity and level of programming, and offers reporting used to measure system change and progress.

MCOs should collaborate with state departments of Medicaid to understand and enhance their existing data exchange systems. In our experience, setting a goal in collaboration with the department of Medicaid to develop and implement a system as described previously—a single source of truth for member information—leads to the most improved member care outcomes.

### Types of data and information that should be exchanged

We recommend a fully integrated data sharing system as described previously. The types of data and information that should be exchanged between the CCE and Aetna MCO include but is not limited to the following:

- Enrollment 834 and demographic data
- Health Industry Number data such as admission, discharge, and transfer data
- Assessment information and care plans
- Provider visits including assessments, diagnoses, interventions, and follow-up visits
- County-level data such as data related to involvement with children's public service agencies
- Data on social or community-based needs as well as closed-loop referral data such as securing a food bank resource for a member and connecting the member to a federally funded program

## e. Care Coordination Staffing Arrangements

Staffing models may consider availability (number) and qualifications (experience and training) to ensure sufficient staffing to meet the needs of members while maintaining a person-centered, integrated approach to care coordination while containing administrative costs.

### Suggestions for care coordination staffing and qualifications, taking into account both quality and administrative expense

We recommend the following care coordination staffing and qualification arrangements to implement and maintain a person-centered managed care model that utilizes integrated, holistic approaches and is mindful of expense. This includes the following:

- Care Coordination teams (comprised of experts in physical health, behavioral health, and social needs) that understand the complexities of the larger system of care
- Use of community health workers (CHWs) who act as extensions of CCEs and the larger care coordination system

- Use of licensed professionals who have the education, expertise, and experience necessary to manage the unique needs of the population and supervise unlicensed and licensed care coordinators, including medical directors where necessary
- Use of peer support staff who offer engagement and connection with difficult-to-engage members
- Training and resources that support behavioral health and social determinants of heath integration on every Care Coordination team

In managed care systems where pharmacy benefit administration is carved out, we recommend MCOs include health plan staff with the education, expertise, and experience to address both system-level and individual member pharmacy issues. Aetna has experience utilizing this model in other Medicaid markets. It has proven effective for problem-solving individual member issues at pharmacy point of sale, enhancing overall pharmacy performance, maintaining budget predictability, and addressing member social needs that impact access to care, thus improving care coordination outcomes.

### How alternative staffing arrangements could be used to efficiently meet individuals' care management needs

Alternative staffing arrangements such as the Pathways Community Hub (PCH) can be used to efficiently meet individual care coordination needs. The PCH model offers engagement opportunities for communities with members who are most at risk through use of evidence-based, physical, behavioral, and social needs intervention. This whole-person approach is focused on modifiable risk factors within medical, behavioral, and social services care and views them as interdependent in their impact.

Each PCH can represent a network of at least 2 and up to 30 community-based organizations (CBOs) that already employ staff with the knowledge and trust of the community to be served. The CBOs deploy and hire (CHWs) who reach out to those most at risk, assess medical, social, and behavioral health risk factors, and confirm that risks are addressed using standardized pathways. The CBO contract with their local hub for outcomes payments achieved by their CHW workforce. The hub establishes financial agreements with available funding, including MCOs and public health entities. The hub provides payment to the network of CBO based on confirmed and comprehensive risk mitigation outcomes as documented. The hub also provides training, technology support, data management, quality improvement, supervision, training, and related services.

The PCH model offers an accountable framework for communities that want to build infrastructure for effective care coordination proven to document both outcome improvement and cost savings. PCHs are accountable to a national certification offered by the Pathways Community Hub Institute and help provide funders and policymakers assurance that community networks have met specific operational, health outcome, and cost-of-care improvement benchmarks that have been demonstrated in peer-reviewed research to produce positive outcomes and cost savings.

The evidence-based, value-based PCH network of community agencies works as a team to identify risk, connect clients to intervention, and track outcomes. The network is accountable in achieving critical whole-person risk reduction outcomes utilizing standardized pathways. Efforts to build sustainable funding streams have led Pathways hubs to develop braided funding streams by contracting with health systems, health plans, and federal, state, and local governments, and in partnership with philanthropy and United Way. Communities working toward and achieving national certification have been able to demonstrate outcome improvements and cost savings.

## f. Monitoring Ongoing Quality of Care Coordination

The use of standardized measures of the quality of care coordination would allow cross-area comparisons and facilitate the identification of targeted improvement opportunities.

### Recommendations and best practices that might help ODM monitor the ongoing quality of care coordination/case management

We recommend the following best practices and strategies to help ODM monitor the quality of care coordination/case management programs:

- MCOs should offer regular gaps-in-care reports that delineate member gaps in care by provider or provider type; examples include inpatient and emergency department utilization or Early and Periodic Screening, Diagnostic and Treatment appointment adherence; gaps-in-care reports offer ODM and MCOs a snapshot of performance for State-required or critical measures; and allow the MCO to provide education, technical assistance, and when necessary, performance improvement support to providers with measures that do not meet the designated standard
- Reports and oversight of value-based solution contracting within the MCO's provider network; ongoing discussion and dialogue on moving providers toward down- and upside risk contracting
- Existence of a population health platform which measures overall population health strategies by health disparities and allows two-way communication

### Approaches that could be used to effectively and efficiently monitor performance of both individual care management/care coordination outcomes, and outcomes for the care coordination/care management program as a whole

We recommend ODM utilize feedback from Medicaid stakeholders and performance measures typically regarded as standards of care for care coordination programs that serve children and adults with complex needs. This may include the following:

- Informal or formal feedback solicited from county agencies, providers, law enforcement, hospitals, members, and other State departments such as developmental disability or juvenile justice
- Data and reports that demonstrate effective system performance such as the percent of assessments and care plans completed within State-required timeframes or the percent of follow-up behavioral health appointments that occur within seven days post-inpatient discharge

We recommend the following approaches to monitor performance effectively and efficiently for care coordination/care management programs as a whole:

- Engagement rates
- Percent of members in higher tiers of complex care
- Successful completion of programs
- Member satisfaction through CAHPS, HEDIS, Net Promoter Scores, or Medicare Dual Star Ratings
- Depending on the pharmacy managed care structure, pharmacy utilization measures, member engagement measures, care coordination activities and drug therapy changes, closing pharmacy gaps in care, medication adherence rates, and/or access to needed medication rates

## g. Structures that Support Care Guide Effectiveness and Timeliness

Defined roles and responsibilities for both MCO and CCE entities would support the Care Guide model of implementation and effectiveness.

### Types of structures and processes that should be put in place to ensure Care Guides can quickly and effectively meet each individual's time-limited needs

We recommend the following processes be put in place to make certain Care Guides can quickly and effectively meet each individual's time-limited needs:

- Make certain care coordination functions are fully delegated to the CCEs with MCOs offering systemic support
- Utilize Care Coordination teams that are regionally located at CBOs where existing staff have the knowledge and trust of the members who live and work in that community

- Include CHWs on all Care Coordination teams who are responsible for making certain members' time-limited needs are met
- Utilize a single care plan that operates as the source of truth and is managed by the CCE care coordinators
- Make certain MCOs, providers, and the community that can offer collaborative member or system level problem-solving are closely linked to CCEs

### How ODM could monitor the quality and effectiveness of the Care Guide program

We recommend ODM monitor the quality and effectiveness of the Care Guide program through oversight delegation. MCOs should have oversight delegation processes in place that include comprehensive reporting capabilities, regular meetings such as Joint Operating Committees that address performance and improvement, and transparent, ongoing communication with providers and the department of Medicaid.

## h. How each type of care coordination role could assist individuals with addressing health-related social needs

We recommend each entity involved have clearly defined roles and responsibilities for addressing health-related social needs that are agreed upon in advance. For example, an MCO can assist by delegating care coordination functions to the CCE, which would be responsible for addressing health-related social needs with each assigned member. In this model, the MCO may offer systemic support such as use of an information system that tracks all referrals by documenting that members are utilizing the resources offered: a closed-loop referral. The MCO could provide reports shared with the CCE to measure performance. When CCEs are designated as primary care coordination entities, care coordinators are responsible for member engagement, facilitating meaningful discussion about health-related social needs, documenting health-related social needs and referrals in the member's care plan, completing follow-up acknowledging member use of referral resources, and documenting and tracking closed-loop referrals.

**Improving Care for Children and Adults with Complex Needs**

13. **Services for Children Involved in Multiple State Systems or with Complex Behavioral Health Needs** — The State recognizes that there are gaps and some unevenness in the availability of services needed by children, youth, and families supported by multiple state systems, and particularly for children with complex behavioral health needs. Thus, Ohio is in the process of transforming its approach. Through the managed care procurement, including phases of activities following contract implementation, ODM, in cooperation with other state child serving agencies, plans to customize the structure and design of the Medicaid program to tailor services to meet the needs of children, particularly for children involved in multiple state systems (e.g., juvenile justice, child protective services, intellectual/developmental disabilities) or other youth with complex behavioral health needs.

    ODM envisions a delivery system structure for children where MCOs, an ODM- contracted Behavioral Health Administrative Service Organization, and a network of regional Care Management Entities will work together to create a seamless delivery system for children, families and system partners. Specifically:

    - MCOs will be responsible for physical health services for all children as well as behavioral health services and care management for children with less intense behavioral health needs.
    - A Statewide Behavioral Health-Administrative Services Organization (BH-ASO) will be responsible for children involved in multiple state systems or with other complex behavioral health needs. The BH-ASO will not be the primary provider of care coordination; rather, they will contract for care coordination and other services with local service providers. The BH-ASO will be responsible for developing and managing a full continuum of behavioral health network providers, to include regional Care Management Entities, with the specific expertise necessary to effectively serve this population. The BH-ASO will also develop the necessary data infrastructure to support providers and coordinate with the MCOs to ensure integration of physical health and behavioral health services.
    - Regionally-located Care Management Entities will serve as the “locus of accountability” for children with complex challenges and their families who are involved in navigating multiple state systems. The Care Management Entities will be responsible for providing and/or coordinating the provision of intensive care coordination, community-based services, and other services and supports to improve health outcomes.

Critical to the success of this transformation is an effective care coordination approach. ODM and its state partners are interested in developing an Intensive Care Coordination model using a High-Fidelity Wraparound approach. ODM is seeking to build upon existing care coordination efforts that currently exists in various localities across Ohio and will develop a Medicaid reimbursable service that supports this approach. ODM is also seeking to develop an approach that will enhance the competencies of entities to provide high-quality, evidence-based Intensive Care Coordination services.

Additionally, Ohio is exploring the need to offer two levels of care coordination, recognizing that not all children need, or may select, to participate in Intensive Care Coordination Using High Fidelity Wraparound, but for whom coordinating with other providers and supports would strengthen their treatment outcomes. ODM is considering the need for a selective contracting model to ensure that only providers with the pre-requisite competencies can be reimbursed for Intensive Care Coordination Using High Fidelity Wraparound; ODM is also considering the relative benefits and drawbacks of establishing geographical boundaries for providers of Intensive Care Coordination

Using High Fidelity Wraparound providers, whereby these providers would be responsible for serving certain areas of the State.

ODM seeks input on the following topics for children involved in multiple state systems or with other complex behavioral health needs:

a. Which subsets of children and youth may benefit from the approach outlines above?
b. Which populations of children and youth should receive Intensive Care Coordination Using High Fidelity Wraparound? Please include suggestions for operationalizing eligibility for Intensive Care Coordination Using High Fidelity Wraparound.
c. What suggestions can you offer to build and expand network capacity to deliver Intensive Care Coordination Using High Fidelity Wraparound?
d. Which populations should not receive Intensive Care Coordination using High Fidelity Wraparound, but instead would benefit from a less-intensive type of care coordination? How should this level of care coordination differ from what children and youth receive today?
e. How might ODM and its state partners develop and use centers of excellence to assist the State in its system and practice transformation efforts? What other strategies have been effective in workforce development and practice transformation?
f. In this proposed model, wherein physical health services are managed by the MCO and intensive behavioral health services are managed by the BH-ASO, what can ODM do to ensure whole person, integrated care? Describe the roles, responsibilities and collaboration between involved entities to ensure care access and continuity for individuals.
g. In an ODM-contracted BH-ASO model, what contractual and operational structures should ODM consider to achieve ODM's goals?

Children who are involved in multiple state systems and those with complex behavioral health conditions and their families often experience significant barriers to treatment. A strong care coordination model is essential to facilitating uninterrupted care between care settings and effective communication between providers, care teams, and government agencies to identify unmet needs and address those needs across the entire care continuum.

## a. Subsets of children and youth that may benefit from the approach outlined above

Children and youth who would benefit from the Ohio Department of Medicaid (ODM) approach outlined involving intensive care coordination and wraparound services include the following:

- Children and youth involved with juvenile justice and Child Protective Services or who are at risk of removal from their home
- Children and youth with intellectual and/or developmental disabilities who are often involved with multiple State agencies
- Transition age youth
- Children and youth with special health care needs such as individuals with multiple complex chronic conditions, comorbidities, co-occurring conditions, or medically complex conditions
- Youth with three or more emergency department visits within one year or previous behavioral health inpatient admissions
- Infants with neonatal abstinence syndrome
- Children and youth with abuse and/or trauma histories with significant social determinants of health needs

- Adolescents who are homeless, at imminent risk of becoming homeless, or have a history of residential instability
- Youth who are likely to experience a rising risk for long-term health and socioeconomic issues, to include foster care or congregate care placement, which may be impacted by trauma-informed practices, approaches, and care. This includes individuals 17 years of age or younger who have received a significant number of treatments or services for high-risk diagnoses or behaviors often correlated with the experience of traumatic events. The high-risk indicators may include physical health, behavioral health, pharmacy claims data, and other relevant predictive measures.
- Children with serious emotional disturbances, such as those targeted by the Medicaid Home and Community-Based Services waiver program and who have a recognized diagnosis with significant functional impairment. This would allow Intensive Care Coordination (ICC) to intervene at an earlier point with newly enrolled children, youth, and young adults and provide increased support and services to avert potential traumatic events, including being placed out of their home. This population may include children with autism spectrum disorder who are in the child welfare system.
- Children at risk of placement, such as those in the home where a parent has an opioid use disorder, could prevent a family crisis and out-of-home placement

## b. Populations of children and youth that should receive Intensive Care Coordination Using High Fidelity Wraparound. Suggestions for operationalizing eligibility for Intensive Care Coordination Using High Fidelity Wraparound.

Children and youth who meet defined screening criteria for an intensive level of care management should be considered for High Fidelity Wraparound (HFWA) services. Several screening tools are available, usually completed by the providers. We recommend that more than one tool be used to allow a comprehensive whole-health assessment in determining level of care coordination and service needs. These tools may assess level of care needed to achieve the best outcomes for the child. The tools will also address child/adolescent functional scales and biopsychosocial needs. At-risk children and youth who could benefit from HFWA services may include those with the following:

- Immediate, current, and past health care, mental health, and substance use disorder (SUD)
- Psychosocial, functional, and cognitive needs
- Social determinants of health including food scarcity, education, and housing status
- Ongoing conditions or needs that require treatment or care monitoring
- Current care being received, including health care services or other care coordination
- Current medications prescribed and level of compliance
- Support network, including caregivers and other social supports
- Other areas as identified by ODM in collaboration with managed care organizations (MCOs)

Consistency of screening and assessment tools across providers is important, yet some flexibility for local communities would prevent overburdening providers with the cost of new tools and staff training. State funding and/or tools in the public domain could address this issue. Examples of evidence-based tools that involve assessment of trauma history, general mental health and substance use, and physical health include the following:

- University of California Los Angeles Child/Adolescent Post-traumatic Stress Disorder Reaction Index
- Trauma Screening Questionnaire
- Early and Periodic Screening, Diagnostic and Treatment Mental Health Assessment
- Child and Adolescent Needs and Strengths
- Child and Adolescent Service Intensity Instrument (CASII) (score >3)
- CRAFFT Screening Tool for Adolescent Substance Abuse
- Patient Health Questionnaire-9

- Psychosocial Pediatric Symptom Checklist 17
- Generalized Anxiety Disorder 7
- Edinburgh Postnatal Depression Scale
- Depression assessment
- Infant assessment
- Pediatric asthma assessment
- Perinatal assessment
- Weight management assessment

## c. Suggestions to build and expand network capacity to deliver Intensive Care Coordination Using High Fidelity Wraparound

One option is capacity development around providers who currently do HFWA services well. Supporting these providers in becoming centers of excellence is one model for capacity building. This could include expanding State-funded training or offering value-based solutions such as incentives for these providers who meet fidelity expectations and a defined level of performance measures. Considerations might include the following:

- Feasibility of providers to offer same-day appointments to serve members who may be at risk for an increase in symptoms
- Timely follow-up with an individual who had a recent crisis episode
- Capacity to respond to urgent situations based on individualized family needs within 24 hours
- Offering transportation to and from support and rehabilitation service activities to include members, family, caregivers, and circle of support
- A culture that supports flexible, creative, and community-based approaches
- Strategies used by the provider to manage risk
- Ability to provide a seamless transition between levels of care along the continuum of service

As an MCO, we would support the State in planning and implementation of opportunities and changes that accompany the Families First Prevention Services Act, focusing funding on preventive services and supports for families to avoid entrance into foster care. In addition, monitoring recommendations from the State-level workgroup addressing needs of children with complex behavioral health needs who are involved with multiple State agencies could offer options that meet local needs and identify local resource gaps.

## d. Populations that should not receive Intensive Care Coordination using High Fidelity Wraparound, but instead would benefit from a less-intensive type of care coordination. How this level of care coordination should differ from what children and youth receive today.

The level of care coordination would be determined by the screening tools noted previously (e.g., CASII) to determine risk stratification. Individuals not meeting the criteria for ICC may include children and youth with ambulatory care-sensitive conditions or disease management conditions (e.g., asthma, chronic heart failure, chronic obstructive pulmonary disease, diabetes, or depression), or referrals from within the MCO plan or from a provider, local agency, or community-based organization that indicates unmet care coordination, social supports, or service needs and/or readmission risks.

Children and their families not meeting the criteria for ICC may benefit from trauma-informed preventive and early intervention practices and principles, leading to a reduction in multiple risk factors and a decrease in foster care placements. Alternative programs such as the Arizona Meet Me Where I Am program may offer children and their families needed services without the HFWA intensity. Services typically include behavioral coaching, skills training, and psychosocial rehabilitation. This may involve

in-home and school-based services focused on empowering families with training and support necessary to manage behavior challenges while teaching their children self-control, coping strategies, and interpersonal skills. Less intensive care coordination could be implemented as a preventive measure to help members and families stay healthy and obtain effective and prompt treatment. Care coordination would remain an important service to ensure access to quality services as well as to promote keeping families together by increasing access to supports and services to address trauma, physical and mental health challenges, SUD, and other critical health and behavioral health needs. Currently, the care coordination resources available to children and families can vary significantly by county. It is recommended that the State assist local Family and Children First Councils to increase consistency of available services and resources to benefit children and families regardless of where they live.

## e. How ODM and its state partners might develop and use centers of excellence to assist the State in its system and practice transformation efforts. Other strategies that have been effective in workforce development and practice transformation.

The center of excellence model brings together a high level of expertise, resources, and best practices focused on medical areas. Centers of excellence can increase the capacity and access to a variety of health care services for specific or special populations. For example, this has been a successful model for integrated health homes bringing together physical health, behavioral health, and social services in a coordinated, person-centered single care plan. For children and youth requiring high levels of care coordination, this can be a successful model, particularly for those with multiple or complex conditions such as autism spectrum disorder, or co-occurring substance use and mental health disorders.

As Ohio focuses on State-level planning and technical assistance for multi-system children and youth for Family and Children First Councils, Public Children's Services Agencies, Boards of Developmental Disabilities, and the Board of Mental Health and Addiction Services, we would suggest learning collaboratives be established and incorporated into the centers of excellence model. These collaboratives could build understanding in the provider community and bring provider-led solutions to many of the complex challenges being addressed.

Strategies focused on system transformation that promotes patient-centered, high-quality services require tools, information, and network support to improve the quality of care, increase patients' access to information, and spend health care dollars more wisely. To strengthen technology and human-operated systems—emphasizing clinician feedback and data analytics—areas to consider include the following:

- Attaining benchmark performance levels on health outcomes and clinical processes
- Avoiding unnecessary use of hospitals, emergency departments, tests, and procedures
- Lowering total cost of care and producing cost savings for payers
- Benchmarking results on patient experience
- Providing patient- and family-centered care, helping to engage patients in both the care process and the ongoing continuous quality improvement process within practices
- Using continuous, data-driven quality improvement practices and converting data into actionable reports for practices
- Creating sustainable business operations
- Practicing quarterly benchmarking with other delivery systems
- Providing training and support for practice coaches
- Practicing redesign techniques and improvement skills and practice facilitation
- Access to experts on practice improvement
- Developing a peer-to-peer learning network comprised of transformation leaders
- Creating a better experience for practices, providers, and patients

- Adapting the health care system so that it rewards value rather than volume, more closely aligning payment with quality of care

Finally, ODM may consider other strategies effective in workforce development and practice transformation, including the following:

- Training requirements and activities to develop a qualified, knowledgeable, and culturally competent workforce
- Trainings specific to hiring, support, continuing education, and professional development
- Adult learning opportunities that are focused, intensive, and aligned with the Substance Abuse and Mental Health Services Administration core competencies for workforce development, federal and State requirements, and the requirements of the Centers for Medicare & Medicaid Services Culturally and Linguistic Appropriate Services (CLAS) Standards
- Training experts/contacts as key personnel and point of contact to implement and oversee compliance with the training requirements, development of a collaborative training plan, and participation in training coordination committees by local and State stakeholders
- Workforce development quarterly updates that include information specific to initiatives and activities shared with MCOs and local stakeholder groups
- Implementation of CLAS as a systemic responsibility, requiring the investment, support, and training of all staff
- Annual evaluation within the areas of cultural competency and workforce development to review the initiatives, activities, and requirements impacting diverse communities, geographical services areas, and the individuals accessing and receiving services

## f. What ODM can do to ensure whole person, integrated care. Roles, responsibilities, and collaboration between involved entities to ensure care access and continuity for individuals.

MCOs doing risk stratification to determine care coordination needs would typically identify children and youth with complex behavioral health issues and/or involved with multiple State agencies as high need. These children would therefore likely be assigned a care manager from the MCO alongside other providers and case management entities. The MCO care manager would have a strong role in ensuring coordination with the behavioral health administrative service organization (BH-ASO) and participate in integrated care planning.

How information is shared is key to cross-system collaboration efforts. For example, a health information exchange system that includes health and social information could provide one place for the care coordinator and other team members to see and understand the whole person. Often, social needs are not included in data exchange systems, which can limit effective coordination and collaboration.

Frequent collaborative coordination opportunities involving the MCO and BH-ASO would facilitate efficient access to care as well as identification and resolution of care gaps in communities. Use of data systems such as defined claims modifiers billed by providers would facilitate communication and identification of individuals with particular care needs. In addition, collaboration by sharing of specific assessments to identify social determinants of health would enhance the interaction with the member and the development of goals and interventions aligned with identified barriers and gaps in care or services.

Beyond data sharing, it is critical that the entities develop collaborative, regularly occurring vehicles for communication among the entities that enhance coordination of care (e.g., a care collaboration rounds meeting held regularly that includes representatives from all entities to discuss populations agreed upon and identified as at risk). Collection and sharing of this data create a process to ensure all members have equal access to benefits and services in a way that considers their values and preferences and overcomes

social/cultural/geographical barriers. In addition, participation by regionally located care management entities (CMEs) in these collaborative care rounds conversations would enhance coordination and foster a focus on the whole person through integrated behavioral and physical health and social factors that the care management entities will identify, such as housing, utilities, food insecurity, transportation, childcare, loneliness, stress, caregiver situation, education and employment, mobile phone access, and environmental safety. Review of the data available when developing the care plan ensures care plan goals and interventions are aligned with identified barriers and gaps in care or services for each individual member.

## g. Contractual and operational structures ODM should consider to achieve its goals

With the establishment of this new BH-ASO, success will rely on clearly defined roles and expectations for entities involved, including the BH-ASO, MCOs, CMEs, and ODM. This may include responsibilities such as which entity provides compliance oversight to ensure availability and fidelity of services and quality of care through provider audits, and which performs utilization management and/or care management related to behavioral health services. Specific protocols regarding how services managed by the BH-ASO integrate with MCO benefits and how MCOs and the BH-ASO would coordinate and communicate in these areas would be important to outline prior to implementation of the model. Other protocols may include how MCOs, BH-ASOs, and the local Family and Children First Councils coordinate roles and responsibilities, including data-sharing responsibilities. As an MCO, Aetna is prepared to work with the State and the BH-ASO during an implementation to make this model a success for Ohio.

There are challenges which can be overcome with effective communication and coordination processes. As more entities are involved, there can be a greater risk of fragmentation of care and creation of potential gaps in care coordination as care coordination becomes more time-consuming and potentially efficient. Data-sharing capacity and interoperability for near real-time data will be an essential element for effective coordination and communication to prevent the loss of critical time in dealing with complex issues and enabling a rapid response for children and families without creating barriers to care. The critical nature of data collection and sharing is paramount and can be a challenge for small community-based organizations that play an important role in rapid access to services. Finally, ODM might consider a bonus schedule for the MCO, CMEs, and BH-ASO to incentivize accountability for effective collaboration and coordination that ensures rapid access to and integration of needed services impacting children’s health outcomes.

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**Improving Care for Children and Adults with Complex Needs**

14. **Behavioral Health Services** — The State continues to work with behavioral health providers, managed care organizations and other stakeholders to stabilize the integration of behavioral health services into managed care.
    a. Do MCOs currently require primary care clinicians to screen members for behavioral health needs (mental health or substance use disorder screens)? What screening tools would you recommend requiring or allowing primary care clinicians to use? Do they capture social determinants of health? What are recommendations for supporting and monitoring primary care clinicians to ensure screenings are being completed? What challenges keep primary care clinicians from completing these screens? How might data be shared between the primary care clinician and the MCO?
    b. What should the array of behavioral health crisis services be for adults? For children/adolescents? Which of these services should be statewide and which should be determined at the local level in partnership with the Alcohol, Drug and Mental Health Boards?
    c. ODM is considering behavioral health performance measures that focus on functional outcomes, improvement in the social distress score, recidivism, retention in care, and timely access to services (e.g., success with referrals). What other measures may be available and should be considered for inclusion?

Addressing member needs in a holistic, person-centered way is key to improving the quality, health outcomes, and experience of individuals through a single integrated care plan addressing the physical health, behavioral health, and social needs of the individual.

## a. Whether MCOs currently require primary care clinicians to screen members for behavioral health needs. Screening tools for primary care clinicians. Whether they capture social determinants of health. Recommendations for supporting and monitoring primary care clinicians to ensure screenings are being completed. Challenges that keep primary care clinicians from completing these screens. How data might be shared between the primary care clinician and the MCO.

In addition to health risk assessments usually completed by managed care organization (MCO) Care Management teams, Aetna expects primary care clinicians to screen their patients for behavioral health and substance use disorders. This offers opportunities for identification and early intervention. For behavioral health conditions, screening is completed for depression, anxiety, and substance use. Many primary care clinicians use best practice screenings such as the Patient Health Questionnaire-2, PHQ-9, or the Generalized Anxiety Disorder-7 scale. The Edinburgh Postnatal Depression Scale is one of several tools commonly used for screening for postpartum depression. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based screening tool used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. SBIRT offers a flexible model for substance use disorder screening and brief intervention by primary care clinicians that can be adjusted to multiple clinical settings. Early identification and intervention can result in a reduction in alcohol and drug use, improvement in quality-of-life measures, a reduction in risky behaviors, and a reduction in time and resources needed to treat substance use conditions. Screening programs have demonstrated cost effectiveness by interrupting drug use patterns before severe addiction develops. While specific tools

could be required, there are numerous evidence-based practice screening tools. Some are publicly available while others have a cost to the provider. It is recommended that providers are given flexibility to use what works best within their practice, as long as it is evidence-based.

For children, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedule guides primary care providers (PCPs) with completing age-appropriate developmental screenings to identify cognitive and intellectual disabilities, as well as behavior and psychosocial needs. Trauma assessment using the Adverse Childhood Experiences questionnaire can assist with the identification of behavioral health and substance use disorders and facilitate early intervention.

PCPs can screen for and capture social determinants of health (SDOH). There are screening questionnaires that focus on food security, housing stability, educational and vocational concerns, access to transportation, and personal safety. In some states, Z-codes on claims are used to capture this information. MCOs typically gather this information as part of care management needs assessments.

MCOs often use claims data such as modifiers for screening activities to track provider compliance with screening requirements. In addition, Healthcare Effectiveness Data and Information Set (HEDIS) measures can be used to monitor PCPs. This could include pediatrician and family practitioner completion of the EPSDT schedule for behavioral health and developmental screenings. MCOs also support providers through monitoring and offering practice-specific feedback based on data analytics to assist providers with understanding their patient population. In addition, opportunities for training through readily accessible means such as online modules can assist providers with implementing effective screening processes.

Challenges for providers include time to complete the screenings, staffing, training and implementation time, patient no-shows, and medical record system configuration. Allowing billing for screening activities encourages providers to complete the screenings.

Data sharing between MCOs and providers is an important component of ensuring screenings occur timely and accurately. The use of a broad health information exchange (HIE) allows efficient sharing of data, enabling meaningful data analytics and collaboration. How information is shared is key to cross-system collaboration efforts. For example, an HIE system that includes health and social information could provide one place for the care coordinator and team members to see and understand the whole person. Often, social needs are not included in data exchange systems, which can limit effective coordination and collaboration. Frequent collaborative coordination opportunities involving the MCO, Ohio Department of Medicaid, and local stakeholders, including providers, would facilitate efficient access to care as well as identification and resolution of care gaps in communities. Use of data systems such as defined claims modifiers billed by providers would facilitate communication and identification of individuals with particular care needs.

## b. The array of behavioral health crisis services for adults and for children/adolescents. Services that should be statewide and that should be determined at the local level in partnership with the Alcohol, Drug and Mental Health Boards.

To best meet the individual's needs at times of crisis, the availability of a full continuum of crisis services able to serve both adults and children is necessary. This includes the following:

- Hotline for triage and warm line availability
- Mobile crisis teams for risk assessment and immediate intervention
- Crisis stabilization and observation units, including detoxification services

- Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance abuse-related services
- Stepdown residential options (typically for less than 16 days)
- Respite care for children and youth
- Access to additional services such as inpatient psychiatric care and brief residential facilities
- In-home services (e.g., Multisystemic Therapy for children and families to prevent out-of-home placement)
- Medication-assisted treatment services for individuals in crisis related to substance abuse to reduce inpatient admissions
- Peer support services for adults, which can provide needed support to minimize the disruptive impact of a crisis
- Other services that impact social needs such as supported housing availability, which can reduce crises precipitated by eviction or loss of housing

We recognize there is variability between counties with smaller and more rural areas often having fewer services than urban areas. As an MCO, we recognize and support all available services sustained through the local Alcohol, Drug, and Mental Health Board and would look to collaborate with these county boards to enhance what is not currently available by increasing access to MCO-covered services to fill gaps in care.

## c. Other measures may be available and should be considered for inclusion

Standardized performance measures offer opportunities to identify areas of success as well as areas for improvement. HEDIS measures include many child and adult measures related to access to treatment and preventive care, including prenatal care during pregnancy. Timely access measures include 7-day follow-up from behavioral health hospital discharge, initiation and engagement of alcohol and other drug abuse or dependence treatment, medication follow-up for attention-deficit/hyperactivity disorder and depression, initial medication prescriptions for children, and well-child visits. Measures from the Consumer Assessment of Healthcare Providers and Systems by the Agency for Healthcare Research and Quality provide the member perspective on access to care. Stakeholder satisfaction measures also offer insight into system gaps and identify opportunities for cross-system collaborations.

Readmission and follow-up measures may offer information on care coordination gaps. Other key measures of quality of care relate to opiate and benzodiazepine combination prescribing, metabolic screening for individuals prescribed psychotropic medications, and many others. Measures related to specific populations can provide information on health disparities such as EPSDT service rates, reduction in family disruptions, improvement in family functioning, reduction in truancy, and engagement in health care, including behavioral health services for children in foster care or juvenile justice systems.

Most MCOs and provider practices are currently familiar with many of these measures. For individuals who receive care management through their MCO, data collection and tracking are facilitated. MCOs, State agencies, and health care and community provider collaborations and data sharing can lead to improved health across the population. MCOs can support provider performance improvement activities through alternative payment models that incentivize services such as well-child visits, prenatal and postpartum care, or other identified gaps in care.

Areas of impact that generally are less frequently measured involve SDOH, yet these areas can have significant impact on health outcomes. For example, access to stable and affordable housing can impact health outcomes as well as health care costs, or programs coordinating with the justice system can improve access to primary, behavioral health, and substance abuse care upon release. Each of these requires strong collaboration and data sharing between multiple State and local systems of care.

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**Improving Care for Children and Adults with Complex Needs**

15. **Opioid Use Disorder and Substance Use Disorder —** Medicaid plays a central role in efforts to address the State's opioid epidemic ranging from the coverage of evidence- based interventions and treatment, providing tools and support to providers, enhancing the State's capacity.
    a. Describe utilization management approaches that ensure individuals have access to substance use disorder services at the appropriate level of care and interventions are appropriate for the diagnosis and level of care.
    b. What efforts are necessary to develop sufficient provider capacity for each level of care, and medication-assisted treatment services in particular, for individuals with substance use disorder and opioid use disorder?
    c. What are ways that the MCOs can support, shape and improve provider performance to expand access and improve outcomes for individuals with substance use disorder and opioid use disorder?

Aetna believes that utilization management (UM) approaches should support high-quality, whole-person care to ensure individuals have access to substance use disorder (SUD) services and that interventions are appropriate for the diagnosis and level of care.

## a. Utilization management approaches that ensure individuals have access to substance use disorder services at the appropriate level of care and interventions are appropriate for the diagnosis and level of care

Managed care organizations (MCOs) should consider individual member needs to identify and address potential disparities to accessing care by making sure **members receive appropriate screening to identify new or emerging needs, including SUD challenges.** Ohio Department of Medicaid (ODM) and the MCOs should promote the use of best practices, including Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Predictive analytics tools should be incorporated into the MCO UM approaches to identify members at risk based on family history with SUD along with social determinants of health. Daily processes and workflows at the MCOs should integrate UM and care management functions as well as social needs to support holistic care for individuals with SUD.

### Ensuring Appropriate Services for Members with Substance Use Disorder

MCOs need to understand the challenges members face with mental health issues, addiction, and trauma, and help members access the care they need in the least restrictive treatment setting possible to maintain safety and facilitate recovery. The SUD and opioid use disorder (OUD) epidemic requires a broad set of solutions, from raising awareness to monitoring prescription patterns, to providing resources like naloxone to reverse overdose, as well as increasing the availability and use of medication-assisted treatment (MAT) programs. Everyone must understand the dangers associated with opioids, including members, providers, and dentists. MCOs should limit the use of opioids to only a short period and set limits for opioid prescriptions to stop patients from receiving large quantities.

MCOs should support providers and members through UM integrated with care coordination that meets members' needs in their home communities and facilitates continuity of care by reducing barriers to SUD treatment, including access to MAT, support programs, and non-pharmaceutical alternatives to treat pain, as well as not requiring prior authorization (PA) for telehealth services.

Doctors and pharmacies are on the front line of this epidemic. MCOs should implement a variety of activities to change prescribing practices, including educating providers about their role by giving them

verifiable prescribing data that providers can use to assess their prescribing patterns compared to their peers. MCOs should identify providers as 'super-prescribers' based on the number of opioid prescriptions with greater than a seven-day supply and provide targeted technical assistance and education to impact their prescribing practices.

MCOs need to fully embrace the application of the American Society of Addiction Medicine (ASAM) criteria and utilize the ASAM criteria when assessing and determining member service needs. To help ensure appropriate access to crucial services, MCOs should follow ODM's PA guidelines for all levels of care for SUD treatment, including not requiring PA for the initial 30-day service residential substance use treatment. The MCO UM approach to appropriate SUD treatment should be informed by the following:

- The use of evidence-based treatments for opioid addiction, particularly MAT
- Counseling and supportive services for individuals with SUD and OUD
- Coordinating care to address physical, behavioral, and social needs, including complex and chronic health issues with providers to address the needs of members who require additional services and care
- Members' needs for alternate treatment and support options such as home health and respite services
- The specific risks to pregnant Medicaid members who struggle with substance use and their newborns at risk for neonatal abstinence syndrome and ensuring timely access to treatment, prenatal care, and newborn care

MCOs should design UM activities to address members who struggle with substance use, including the following:

- Conducting routine review of UM guidelines to help support appropriate and necessary utilization of opiates, such as the following:
  - Trial and failure of opiates, tramadol, and buprenorphine are not required to meet medical necessity criteria that require failure of analgesics (pain medications) prior to other pain management therapies or procedures
  - Routine review of coverage, criteria, and quantity limits for non-medication pain management services, such as acupuncture, physical therapy, and massage therapy
- Increasing access to MAT by removing barriers to treatment and driving adherence
- Reviewing claims data and reports to identify over- and under-utilization and identify solutions for appropriate utilization, such as targeted provider education and assistance
- Supporting and promoting naloxone co-prescribing
- Providing referrals for clinical counseling
- Coordinating with network pharmacies on the use of point of sale safety edits
- Supporting safe prescribing practices through use of PA/UM edits, daily dose limits, tightened PA criteria, and monitoring for multiple prescribers or multiple pharmacies

## Utilization Management Guidelines

MCOs should use nationally recognized, evidence-based criteria as UM guidelines applied based on the needs of individual members, including the following:

- Criteria required by ODM or federal regulatory agency
- ASAM
- Milliman Care Guidelines for physical health (PH) and behavioral health (BH) criteria
- Level of Care Utilization System: BH services for adults
- Children and Adolescent Service Intensity Instrument: BH services for children
- Aetna Clinical Policy Bulletins
- Aetna Clinical Policy Council Review
- eviCore healthcare Clinical Guidelines
- National Comprehensive Cancer Network Guidelines

MCOs should review provider-specific approvals and denials to identify opportunities to streamline services for members and processes for providers by reducing the number of procedures requiring PA. Members with needs related to substance use should be assisted with managing their utilization of the health care system including education, referrals, communication with providers, pharmacy restriction (when appropriate) to select providers, pharmacies, and/or the placement of medication limits when indicated.

### Training for Utilization Management and Clinical Staff

MCO UM staff should have expertise in PH and BH and waiver programs, as well as experience and training working with adults and adolescents with SUD. Staff should receive training to combine clinical skills with service techniques to support UM processes, including PA, concurrent review, and retrospective review of services. UM staff should participate in a rigorous, comprehensive core training program that includes daily, monthly, quarterly, and annual ongoing training opportunities.

## b. Efforts necessary to develop sufficient provider capacity for each level of care, and medication-assisted treatment services in particular, for individuals with substance use disorder and opioid use disorder

MCOs should identify network gaps and opportunities for improving member access to each level of care for SUD and OUD services, including MAT and supportive services. MCOs should monitor provider compliance with required time, distance, and appointment wait time standards and employ ongoing maintenance strategies to ensure the SUD and OUD service needs of our members are met. ODM and the MCOs should collaborate with providers to increase adoption of MAT through providing education, technical support, and promoting adoption through value-based contracting and the recognition of quality MAT providers. For rural areas in Ohio, efforts are necessary to develop and enhance telehealth options. Having an authorized telehealth facility in each region would allow members to access the full spectrum of services for SUD and OUD.

## c. Ways the MCOs can support, shape, and improve provider performance to expand access and improve outcomes for individuals with substance use disorder and opioid use disorder

MCOs can develop a variety of initiatives to support, shape, and improve provider performance to expand access and to improve outcomes for individuals with SUD and OUD. These initiatives could include the following:

- **Training and technical assistance:** MCOs can offer provider education and training through several mechanisms, including fax blasts, provider portal, provider forums, and newsletters. The trainings cover a variety of topics, including but not limited to MAT, care management, care plan and collaboration process, and SBIRT.
- **Predictive analytics:** MCOs should use predictive analytic tools that support identification of member risk based on such things as family history and social determinants of health. The information from predictive analytic tools should be aggregated and used to identify opportunities to expand networks and work with current providers to enhance service availability.

To further expand access to needed services, MCOs should develop initiatives to increase the number of providers providing MAT and supportive services, establish a center of excellence (COE) model for suboxone treatment and pain management to incentivize and reward providers that adhere to best practices and improve health outcomes, and develop value-based purchasing arrangements. MCOs should support Office Based Medication Assisted Treatment and Office Based Opioid Treatment (Office Based Addiction Treatment or OBAT) programs, including State training such as the Ohio Department of Mental Health Addiction Services Data 2000 Prescriber Training for Medication Assisted Treatment. By

providing bundled billing to MAT and OBAT gold card providers/COE, MCOs could further remove administrative barriers to care while enhancing member access and creating additional supports.

The SUD and OUD epidemic requires a broad set of solutions—such as raising awareness, monitoring prescription patterns, providing resources like naloxone to reverse overdose, and increasing the availability and use of MAT programs. Removing stigma from seeking treatment for addiction is a critical element. Educational programs to teach providers, community stakeholders, and member supports to identify and respond when someone is experiencing a mental health or substance abuse problem are key, and more effective treatment regimens can help lower the rate of relapse.

**Improving Care for Children and Adults with Complex Needs**

**16. In Lieu of Services —** ODM currently only recognizes Institutions for Mental Disease as in lieu of services. Are there other in lieu of services that ODM should consider for approval that would be cost effective alternatives to the current service array?

Aetna's Medicaid experience informs us that accomplishing the personal wellness and prevention goals of our members is complex and everchanging. We also know that members are unique and there are times when existing covered services do not completely address their health needs.

Aetna appreciates the Ohio Department of Medicaid's (ODM) consideration of additional in lieu of services for increased personalized member care. The following proposed solutions will keep the member as the focus, be cost-effective, and improve quality of life and health outcomes.

## Maternal and Child Health Services

Aetna is proposing the following in lieu of services to support ODM's "Initiatives to Support Ohio's Children and Families," as outlined in ODM's annual report published in August 2019:

### Collaboration with Community-based Organizations to Support Mothers and Their Babies

**Value of benefit:** Infant mortality is affected by race and geography, and reducing the racial disparity gap in infant mortality is challenging. We fully support ODM's development of the Mom & Baby Bundle program and maternal and infant mortality improvement investments to decrease preterm births, decrease infant mortality, and improve maternal health.

**Description of benefit:** Evidence-based support programs for pregnant and postpartum women. Aetna foresees an opportunity to collaborate with community-based organizations providing support programs to pregnant and postpartum women. These organizations include Birthing Beautiful Communities, CelebrateOne, Cradle Cincinnati, First Year Cleveland, Getting to 1, Maternal, Infant, and Early Childhood Home Visiting program providers, Moms2B, MY Baby's 1st, Pathway Community HUBs, Providence House, and Restoring Our Own Through Transformation, to name a few. Services vary by organizations, but supports include overcoming social determinants of health such as housing barriers, education, and employment challenges; breastfeeding supports; safe sleep; connections to social supports; health literacy; parenting programming; and bonding and attachment.

**Goals of benefit:** Improve maternal and child health outcomes; reduce extended hospital stays, unnecessary emergency department (ED) visits, and premature births; and connect mothers to the social services and benefits needed to accomplish these goals.

### Doulas Services for Healthier Pregnancies and Deliveries

**Value of benefit:** The evidence suggests doulas working with our pregnant members supporting their emotional, physical, and informational birthing experience accounts for a reduced need for clinical procedures during labor and birth, fewer birth complications, and more satisfying experiences during labor, birth, and postpartum.[1]

**Description of benefit:** Expectant and postpartum mothers will receive support from doulas for a healthy, satisfying experience. Doulas typically begin working with the mom in the second or third trimester and teach the mom relaxation and breathing skills; answer questions about the birthing process; help the mom

[1] Gruber, Kenneth J., Cupito, Susan H. and Dobson, Christina F. "Impact of Doulas on Healthy Birth Outcomes," *The Journal of Perinatal Education*, 22(1) 49-58 (2013): accessed February 21, 2020; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/.

understand labor and delivery procedures and possible complications; help develop a birth plan; and more. During delivery, the doula provides comfort and support using massage and touch techniques; makes sure the mom is receiving adequate nutrition and hydration; and helps communicate with the mom's spouse, partner, and/or family, and medical staff. When the mom and baby return home, the doula can teach the mom and other parents how to care for baby, assist with breastfeeding education, and provide care for the mom.

**Goals of benefit:** Reduce premature births and unnecessary ED visits.

## Transitional Care Services for Mothers, Babies, and Families with a History of Substance Use during Pregnancy

**Value of benefit:** Transitional care services for postpartum mothers with substance use disorder (SUD) will support the medical and behavioral needs of mother and baby with a goal of maintaining the family unit, reinforcing the mother-baby dyad, and avoiding entrance into kinship care or foster system. The focus will be on treatment and supporting the family unit postpartum and in transition to parenthood.

**Description of benefit:** Aetna proposes collaborating with short-term residential facilities that treat mothers with SUD. The goal would be to keep the mother engaged in prenatal and postpartum care as well as engaged in SUD treatment. These facilities offer a variety of habilitative and rehabilitative services to residents including focus on their emotional, social, and life issues; parenting skills groups; 12-step group involvement; anger management; family addiction education; individual and group therapy; relapse prevention planning; trauma-informed care; medication management; and medication-assisted treatment. This benefit would cover habilitative and respite services as well as care coordination using existing community health worker programs like Pathways.

**Goals of benefit:** Reduce instances of SUD and mother/child separation through child welfare placement.

## Housing Transition/Navigation Services

**Value of benefit:** In Ohio, more than 10,000 people experience homelessness on any given day.[2] As a result, there is a need to provide services for individuals with complex and frequently occurring issues that are challenged with accessing and maintaining stable housing. Transitional housing is a temporary solution designed to support individuals from homelessness to permanent housing by offering structure, supervision, behavioral health (BH) support, life skills, education, and training. Transitional housing allows time for housing permanency plans to be created.

**Description of benefit:** Aetna proposes expanding the resources and services available to individuals with recurring issues who do not have stable housing and/or are at risk for homelessness. This includes coordinating substance use rehabilitation and recovery services, services and programs to meet a member's post-discharge social needs, and habilitation services for lifestyle and employment support.

**Goals of benefit:** Reduce homelessness, unnecessary ED visits, hospitalizations, and readmissions.

## Respite Care Services

**Value of benefit:** Expanded respite services are important for caregivers of members with complex needs who have a difficult time planning for breaks in the care they provide. Caregivers' health can be at risk with high amounts of stress and responsibilities. Respite care can strengthen and keep struggling families together by planning strategic breaks for either or both the member and the family on a regular basis, as they participate in ongoing care services.

[2] United States Interagency Council on Homelessness: accessed February 13, 2020.

**Description of benefit:** Aetna proposes expanding respite care services to members 21 and older. Respite care gives caregivers temporary self-care time and provides alternative care resources for the members. These services can be provided in the home or in an adult day setting. Skilled respite care can be provided for members with a skilled need. This benefit would assure quality care for the member while the caregiver is given support and assistance.

**Goals of benefit:** Prevent unnecessary ED utilization, reduce caregiver burnout, and support BH issues and costs associated with caregiving.

## Peer Support Services

**Value of benefit:** Peer support services align with the Ohio stakeholders' theme of providing more personalized care for members. According to the Substance Abuse and Mental Health Services Administration, "Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process."

**Description of benefit:** Peer support services are utilized in a variety of ways, including the following:

- Engaging peer support services while members are inpatient through collaboration with community-based organizations (CBOs) providing these specialized services. Including peers in the discharge planning process can result in impressive outcomes for reduced readmissions. Peers remain with members providing continued support following discharge to the community.
- Conducting face-to-face visits with peer support workers in a community setting of the member's choice with a focus on helping members achieve their person-centered goals for their wellness.
- Using peer support workers for coordination with CBOs to refer members to appropriate services for addressing and resolving social needs that can worsen health or increase avoidable ED visits. For example, members can be connected to peer support services through Assertive Community Treatment and Permanent Supportive Housing program teams.
- Collaborating with a managed care organization's Population Health Management team to provide member education and link them to the services, tests, and screenings needed.
- Working with members on self-management activities such as self-care, managing a budget, and paying bills.

**Goals of benefit:** Improve health outcomes, increase self-sufficiency, and reduce readmissions, ED visits, and BH costs.

## Healthy Meal and Food Services

**Value of benefit:** Separate studies published in JAMA Internal Medicine[3] and Health Affairs[4] describe the medical and economic benefits of medically tailored meals. Researchers found a reduction in health care costs among people receiving medically tailored meals. The savings were a result of a reduction in admissions to hospitals and nursing homes and fewer ambulance trips and ED visits.

A new clinical trial at the Ohio State University Comprehensive Cancer Center—Arthur G. James Cancer Hospital and Richard J. Solove Research Institute and three other leading cancer centers aims to reduce

[3] Berkowitz, Seth, Terranova, Jean, and Randall, Lisa. "Association between Receipt of a Medically Tailored Meal Program and Health Care Use," JAMA Internal Medicine, 2019 (179-6) 786-793: accessed February 13, 2020; https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2730768.

[4] Berkowitz, Seth, Terranova, Jean, Hill, Caterina, Ajayi, Toyin, Linsky, Todd, Tishler, Lori W. and DeWalt, Darren A. "Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries," Health Affairs, April 2018, Volume 37 (4): accessed February 13, 2020; https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0999?journalCode=hlthaff.

malnutrition among patients with lung cancer by offering nutritional counseling and medically tailored meals to at-risk patients.

**Description of benefit:** Aetna recommends comprehensive meal and nutrition services be offered as an in lieu of service. This would include medically tailored meals, home produce delivery, and food prescription programs. The program benefits and evidence-based nutrition interventions can include the following:

- **Medically tailored meals:** Availability of multiple portioned meals daily from community-based organizations to eligible members through home delivery or community site locations. These programs can include nutrition education and/or counseling from registered dietitians for a comprehensive service offering.
- **'Rescue' produce:** Home delivery of imperfect or surplus produce that is not ideal for retail distribution. The produce is delivered to individuals based on diagnosis and includes recipes.
- **Food prescriptions:** Vouchers provided to individuals to acquire produce through community resources such as farmers markets or community-supported agriculture programs.

**Goals of benefit:** Improve health outcomes and reduce ED visits, inpatient admissions, readmissions, and comorbidities.

**Supporting Providers in Better Patient Care**

17. **Centralized credentialing —** ODM intends to centralize provider credentialing and re-credentialing. MCOs will accept provider credentialing information from ODM and will not request any additional credentialing information from a provider. MCOs will potentially participate in the ODM -led credentialing committee. MCO responsibilities will include providing credentialing files prior to the start of operation, negotiating and executing provider contracts, notifying ODM of denied provider applications, loading providers into their claim system, and reporting provider information (e.g., member complaints, quality of care issues, changes in provider information, and any provider terminations) to ODM. MCOs will terminate their contracts with providers whose credentials are terminated by ODM.
    a. Please identify any potential barriers to implementing this approach and proposed solutions.
    b. For MCOs, does your organization have delegated credentialing contracts with health care providers? If so, please provide an estimate of the number/percentage and types of providers in your organization's Medicaid network who have delegated credentialing status.

Aetna supports the Ohio Department of Medicaid's (ODM) intention to centralize provider credentialing and recredentialing activities within ODM. Centralization should reduce administrative burden for providers and help them maintain their focus on delivery of the highest-quality, individualized care to Ohioans enrolled in Medicaid.

## a. Potential barriers to implementing this approach and proposed solutions

We have learned from experience the planning and operational steps necessary to transition to a centralized credentialing system and identify the time to implement such a change as the greatest challenge and potential barrier. The process of implementing centralized credentialing can take as many as six to twelve months. Potential barriers to implementing ODM's proposed approach include the following:

- ODM will need to obtain information regarding the managed care organizations' (MCOs') current-state forms and required evidentiary documentation, processes, and means of handling credentialing and recredentialing applications to gauge the differences across MCOs and to assess how extensive the changes relative to the future state model will be compared to current state
- ODM will need to establish recommended final forms and evidentiary documentation, processes, and/or requirements with input from each of the respective MCOs and corporate teams (e.g., legal, compliance, and program integrity)
- Once revised forms and processes are agreed to, ODM and each MCO will need to initiate their respective implementation plans, which may require additional resources; indeed, some requirements may include capital investments and information technology resource commitments
- Training of MCO and provider staff will be required prior to go-live with credentialing new processes

To address a possible lengthy implementation time and ensure a smooth, effective transition to centralized credentialing, Aetna suggests that ODM meet with awarded MCOs early and regularly to work collectively to create an implementation project plan that addresses all operational steps and identifies realistic completion date expectations. These planning meetings should include discussions regarding the following:

- Clear instruction for provider file data sets the MCOs must initially provide
- MCO process to access credentialing data gathered and stored by ODM
- Expected credentialing process turnaround times, both for ODM and MCO tasks
- Acceptable evidentiary/supporting credentialing documentation
- Incorporation of MCOs' internal credentialing committees in the ODM committee

- Provider credentialing oversight to meet the Centers for Medicare & Medicaid Services program and internal audits requirements
- Definition of provider information or status change scenarios requiring notification and who is responsible
- Responsibility for monitoring, researching, and resolving data integrity issues

## b. Delegated credentialing contracts with health care providers. Estimate of the number/percentage and types of providers who have delegated credentialing status.

Aetna delegates credentialing to providers in Medicaid networks. Typically, 20 to 25 percent of our entire provider network (by Medicaid state) is contained within a delegated credentialing agreement.

**Supporting Providers in Better Patient Care**

18. **Standardizing Provider Requirements —** Stakeholders have strongly advocated to reduce the administrative burden on providers, which detracts from provider focus on delivering quality care, by standardizing administrative requirements for providers. To address underlying concerns, ODM is considering adding the requirements below:
    - MCO use of only state developed standardized prior authorization and concurrent review forms and processes, without additional MCO-specific forms or required information.
    - Standardized provider dispute resolution process across all MCOs.
    - MCO use of American Society of Addiction Medicine criteria for review of substance use disorder service requests.
    - MCO use of state developed medical necessity guidelines, where they exist, to conduct prior authorization and concurrent review.
    - Prior review and acceptance of MCO policies as they relate to implementing state developed medical necessity guidelines.
    - Prohibition of MCO application of prior authorization for certain services as determined by ODM.

    a. Identify unintended consequences ODM should be aware of when considering these requirements.

    b. ODM also plans to establish appointment availability standards. Describe best practices for monitoring appointment availability that minimize provider burden.

    c. Describe strategies for MCOs, individually and collectively, to regularly consider and reduce provider burden and support greater consistency across MCOs.

Aetna supports process improvements that offer consistency and reduce provider burden, as this enhances providers' ability to prioritize quality member care.

## a. Unintended consequences ODM should be aware of when considering these requirements

We believe standardization can be implemented in ways that balance the managed care organization's (MCO) responsibility and oversight with the goal of minimizing duplicative or inconsistent processes across the plans through using State-developed or required forms, processes, and criteria. As changes are developed and implemented, potential unintended consequences should be considered.

### MCO use of only state developed standardized prior authorization and concurrent review forms and processes, without additional MCO-specific forms or required information.

The development and implementation of standardized prior authorization (PA) and concurrent review forms and processes could result in the awarded MCOs not having access to information they used to be able to assess or turnaround time expectations that may have an impact on staffing needs. This potential issue can be addressed if the Ohio Department of Medicaid (ODM) develops new forms, processes, and required turnaround times in partnership with awarded MCOs. Additionally, MCOs currently may manage PA through different means (e.g., phone, fax, email, or other electronic submission tools). Aetna has broadened its use of electronic platforms to process many types of PA as we recognize these tools minimize burden and costs in staff time (both for MCOs and providers) for services for which these systems are appropriate. If MCOs will be required to utilize new electronic platforms, there may be

system configuration, training, and implementation timeframe issues to consider. Reverting to less sophisticated processes (such as processing via phone, email, or fax) when electronic platform tools are available may cause added delays. With respect to any changes, it will be important to build time in for training of providers regarding new processes.

### Standardized provider dispute resolution process across all MCOs.

Aetna believes a standard, consistent provider dispute resolution can lead to streamlined and successful provider issue resolution. In some cases, however, MCOs may currently apply flexibility with respect to provider disputes that can be addressed through informal collaborative resolution with the provider. A standardized process that does not allow for flexibility in appropriate situations may force providers into lengthier or more complex issue resolution processes. Additionally, MCOs may currently engage in different dispute processes for participating versus non-participating providers, as well as different processes for pre-service versus post-service disputes. A one-size-fits-all approach may not consider these situational differences.

### MCO use of American Society of Addiction Medicine criteria for review of substance use disorder service requests.

The American Society of Addiction Medicine (ASAM) criteria are commonly used by MCOs across the country in substance use disorder authorization reviews. There would be minimal clinical training or theoretical impact with a requirement that the ASAM criteria be used. However, some MCOs may currently use tools that simplify the application of ASAM criteria for the purpose of more efficiently managing service requests. Therefore, if the implementation of the ASAM criteria does not allow for use of these tools, there may be some administrative workflow, policy change, and turnaround time implications.

### MCO use of state developed medical necessity guidelines, where they exist, to conduct prior authorization and concurrent review.

To the degree that the ODM develops or requires medical necessity guidelines different from established guidelines the MCOs may currently use (such as Milliman Clinical Guidelines or InterQual), there will be policy, training, system configuration, and workflow factors to consider. Additionally, while a standard set of medical necessity guidelines aim to foster consistency, clinical leadership within the MCO may have a different view of the standard of care; there may be some variation in the interpretation of the required criteria by individual MCOs. ODM may need to identify the mechanism by which it will ensure that all MCOs are applying the criteria consistently, which may result in additional administrative work for both ODM and MCOs. Providers will likely also need additional training regarding the new criteria and any resulting process changes.

### Prior review and acceptance of MCO policies as they relate to implementing state developed medical necessity guidelines.

Aetna does not anticipate a significant unintended consequence related to ODM review of MCO policies about implementation of State-developed medical necessity guidelines.

### Prohibition of MCO application of prior authorization for certain services as determined by ODM.

Aetna is aware that highly restrictive PA structures can result in treatment delays, adverse outcomes, and excessive provider burden. Significant changes to the services that require PA (or limitations on case-by-case flexibility related to which require PA) may impact an MCO's ability to manage providers and services or create additional hurdles for providers to deliver care to members. Eliminating PA requirements for some services may reduce the MCO's capacity to monitor services that tend to be over-

utilized or abused. This can have impacts on cost structure and may lead to the need for rate adjustment negotiations. The addition of services that require PA may require an MCO to institute new workflows or hire additional staff. We may also be limited in our ability to offer highly performing providers reduced PA requirements and administrative burden. The addition of services requiring PA increases the volume of care in fee-for-service types of arrangements, as opposed to alternative payment models that providers seek which focus on performance to benefit member care.

## b. Best practices for monitoring appointment availability that minimize provider burden

While information regarding appointment availability standards can be gleaned through member feedback (in surveys, through the Member Services department, from Grievance and Appeals, or the Member Advisory Councils), it is important to measure appointment availability on a larger scale without creating an arduous tracking or reporting process for providers. An alternative method includes conducting telephonic surveys of a randomly selected set of providers (at predetermined frequencies) to inquire about the ability of the provider to meet established appointment availability standards. The process may focus on surveying certain provider specialist types, if appropriate. It can be beneficial to use an outside vendor to conduct these surveys, from both a staffing resource standpoint and the need for an objective assessment.

## c. Strategies for MCOs, individually and collectively, to regularly consider and reduce provider burden and support greater consistency across MCOs

MCOs engage in a variety of strategies, individually and collectively, to regularly consider and reduce provider burden and support greater consistency. Generally, the goal of ODM requirements should be to foster strong relationships between MCOs and providers through transparent and frequent communication. MCOs should be encouraged to engage in collaborative communication with providers, other MCOs, and ODM, including discussion around processes that may unnecessarily create additional administrative burden and get in the way of service delivery. The following are specific strategies:

- Establish a Joint Operating Committee including providers, vendors, and other MCOs around the issue of administrative burden to identify for problematic trends or process bottlenecks to identify process improvements
- Schedule regular meetings with various health systems and provider associations to facilitate surveys that help identify and inform needed provider-related process improvements
- Utilize Provider Relations staff to identify various provider issues on the ground and bring forward to internal committees for discussion and resolution as well

ODM might also consider requiring MCO participation in collective provider forums or meetings (perhaps quarterly) as an additional means to identify potential opportunities for process improvement and discuss solutions.

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**Supporting Providers in Better Patient Care**

19. **Workforce Development —** ODM is interested in requiring MCOs to actively participate with each other, ODM and other stakeholders to develop a collective impact approach to workforce development. This could include participating in a stakeholder workgroup to identify target areas and potential strategies, conducting workforce analyses, developing a workforce development plan, and implementing strategies to address target areas. Please provide your ideas for how an MCO could work with ODM and other stakeholders (including other MCOs in the same region/state) in workforce development.

Aetna supports the development of a collective impact approach to workforce development in which managed care organizations (MCO) would be required to actively participate with the Ohio Department of Medicaid (ODM), other MCOs, and other stakeholders. We would also support MCO participation in stakeholder workgroups to identify areas for targeted workforce development efforts (e.g., behavioral health specialists, same-day mental health assessment providers, home health aides, and registered nurses) and establishment of potential strategies to develop Ohio's workforce. The stakeholder workgroups could include the participation of representatives from local community-based organizations (CBOs), county workforce development boards, the state department of education, Ohio Department of Job and Family Services, JobsOhio, and the Ohio Association of Community Health Centers Primary Care Workforce Initiative, among other local entities. The specific task of workgroups could include conducting workforce analyses, creating regionalized workforce development strategies, developing a joint workforce development plan, and implementing the plan in collaboration with all of the participating partners.

Workforce development initiatives could include collaboration with local universities and community colleges to develop programs aimed at filling workforce gaps and addressing workforce challenges. Other specific strategies the stakeholder workgroup can develop include the following:

- Partnering with CBOs that offer job training and internship programs, such as Youth Opportunities Unlimited
- Identifying, supporting, and expanding scholarship opportunities
- Bringing any affiliates or parent companies of MCOs to the table to leverage the full power of the MCO organization
- Developing reporting requirements for MCOs to inform ODM of their participation in workforce development activities and the results of these efforts

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**Creating Greater Confidence in the System through Transparency and Accountability**

**20. Program Integrity —**

**a.** Pre-payment review activities by an MCO may lead to fewer referrals for fraud, waste and abuse. Please describe the types of pre-payment review activities an MCO might conduct and how an MCO could quantify, and demonstrate to ODM, the amount of cost avoidance due to these activities.

b. What metrics would you suggest for ODM to measure the efficacy of an MCO's fraud, waste and abuse activities, including number of referrals?

c. How should an MCO adjust its program integrity approach for value-based payment models such as incentive payments, shared savings, episode-based payments, and sub-capitation? Please describe examples of how this may be operationalized.

Aetna recommends the Managed Care Organizations (MCO) conduct prepayment reviews that include prior authorization reviews and data analytics with detailed reporting for each of the cost saving mechanisms to demonstrate to the Ohio Department of Medicaid (ODM) the level of savings achieved. Prepayment review processes can detect potential enrollee, provider, and out-of-network provider fraud, waste, and abuse (FWA).

## a. Types of pre-payment review activities an MCO might conduct and how an MCO could quantify. Demonstration to ODM the amount of cost avoidance due to these activities

MCOs can use data analytics and predictive modeling to monitor provider utilization practices and identify those falling outside of normal activity. MCOs can detect FWA through front-end automation of correct coding and medical policy decisions specific to Medicaid. These activities support the detection of coding irregularities, conflicts, or errors as well as help MCOs identify opportunities for remediation. Prepayment review activities can specifically identify and lead to FWA investigations through active and innovative data mining for specific procedure codes and code combinations that warrant additional review resulting in quantifiable cost savings.

MCO cost avoidance efforts can include the following:

- Claims adjudication system edits for prepayment review and analysis assessing such items as specific benefit limits, lifetime benefit rules, appropriateness of provider type, and previous claims history
- Prior authorization enables cost avoidance by monitoring the use of defined outpatient services and procedures as well as non-emergency or elective hospitalizations before the enrollee receives the service
- One-hundred-percent claim audit for high-dollar claims
- Special Investigations unit (SIU) prepayment system proactive discovery of new fraudulent schemes, allowing for near real-time prepayment review capabilities to flag suspicious claims prior to adjudication

Examples of situations for investigation within a prepayment case could include the following:

- Billing inappropriately per hour instead of per diem, an example of which could occur with adult daycare services
- Billing for services not provided
- Billing for services not medically necessary
- Providing services for more hours than needed

## b. Metrics for ODM to measure the efficacy of an MCO's fraud, waste, and abuse activities, including number of referrals

One measure of success in FWA is leadership in uncovering new emerging FWA schemes and trends that become the standard across MCOs and perhaps even states. Increasing internal and external referrals is also an important measure of success in gaining collaboration with new partners to detect and prevent fraud leading to greater upfront integrity of payment reducing the need to 'pay and chase.' We recommend that ODM consider measuring the number of referrals made to ODM and those accepted by the Medicaid Fraud Control unit and assessed based on the amount of each MCO's membership. Additional measures may include savings, prevented losses, and identified overpayments in addition to recoveries.

## c. How an MCO should adjust its program integrity approach for value-based payment models such as incentive payments, shared savings, episode-based payments, and sub-capitation. Examples of how this may be operationalized.

MCOs should attempt to uncover FWA with robust processes everywhere it exists through consistent SIU practices, prepayment, and other processes across all payment models. MCOs should routinely check the following resources to identify providers who have been excluded from participating as a Medicaid provider in the following sources:

- State licensing boards
- Drug Enforcement Administration Clinical Laboratory Improvement Amendments
- Death Master File from Social Security
- CMS National Plan and Provider Enumeration System
- National Practitioners Data Bank
- Office of Inspector General's List of Excluded Individuals/Entities
- System of Award Management

ODM can direct MCOs to consider variances in provider contract language and responsibilities in relation to value-based payment mechanisms as they seek to prevent and detect FWA. We recommend that MCOs use consistent FWA methods and mechanisms for all providers, in multiple ways, paying attention to industry and state trends and staying ahead of nefarious processes. Through person-centered, value-driven, and innovative approaches robust program integrity programs consistently and proactively prevent FWA. Through these methods, MCOs will identify potentially improper payments and other potential FWA to validate the proper expenditure of State and federal tax dollars.

MCOs should train internal staff on provider value-based arrangements billing processes to identify potential FWA and include billing criteria in accord with provider contract requirements. When MCOs receive FWA referrals, they can review a provider's billing history with the providers payment arrangement to identify potential billing outliers.

**Creating Greater Confidence in the System through Transparency and Accountability**

**21. Data and Information —**

a. Describe best practices for exchange of care management information (e.g., assessment, plan of care, notes, referrals, alerts) between the MCO and contracted and non-contracted care management entities (e.g., ODM, partner state agencies, local administrative agencies, state vendors).

b. Describe best practices for MCOs to provide ODM with real-time access to their data systems (e.g., virtual access or having ODM staff onsite).

c. Describe how MCOs could use Ohio health information exchanges and/or other real time data to deliver services and improve health outcomes. What data elements can the MCO share and what is the format of the data? Describe the extent of current utilization of a health information exchange by the MCO and network of providers. Describe ideas of how to work with other MCOs to standardize the approach to data-sharing.

d. Describe best practices for MCO integration of the MCO's internal systems and incorporation of data from contracted vendors.

e. Describe considerations that would impact an MCO's ability or plans to apply real-time eligibility updates.

f. Describe how MCOs might use data and systems to improve the accuracy and timeliness of individuals' eligibility and demographic information, including when an individual's eligibility is pending redetermination.

g. Describe existing data, other than claims data, that could be used to inform population strategy.

Aetna recognizes "support for increased transparency and accurate data sharing between managed care organizations (MCOs)" was identified as a feedback theme by providers and provider associations as a result of approximately 50 meetings statewide with the Ohio Department of Medicaid (ODM). Our objective in responding to **Question 21a** through **Question 21g** is to fully support ODM as it addresses these issues.

## a. Best practices for exchange of care management information between the MCO and contracted and non-contracted care management entities

The currently recognized standard or best practice for exchanging care management information between MCOs and contracted care management entities are the nationally recognized X12N-Insurance Transaction Sets and related electronic data interchange (EDI) standards and extensible markup language (XML) schemas. These secure and Healthcare Insurance Portability and Accountability Act (HIPAA)-compliant standards enable MCOs to share standardized care management data, such as assessment, discharge, and transfer (ADT) data across multiple health plans. In addition, large provider practices that are engaging in the use of EDI can access and share data with care managers to support the care management function. For example, MCOs that use this approach can exchange member information prior to member transitions to a different level of care. These plans would use a Secure File Transfer Protocol (SFTP) to exchange the member's prior authorization details, which facilitates the continuity of a member's care.

Internally, this data can be distributed to an MCO's Care Management team and can include the following real-time data:

- Clinical and care data

- Population health data that supports providers closing members gaps in care
- Healthcare Effectiveness and Data Information Set (HEDIS) measures and other value-based contract metrics

This data also can be leveraged by an MCO's Quality Management team for monitoring clinical metrics and used by an MCO's Health Informatics team to analyze potential clinical trends and other population health metrics.

These standards, along with the use of SFTPs and secure electronic connections, support the bidirectional transfer of clinical data and documents with state agencies and other recognized stakeholders. For example, 'flat files' can be sent to ODM on a quarterly basis that includes care management information such as member engagement, health risk assessment, risk stratification, and population health management data.

## b. Best practices for MCOs to provide ODM with real-time access to their data systems

The recognized MCO best practices for providing real-time access to an MCO's data systems include providing onsite access for audit purposes, for process simulation purposes, or to describe single case attributes. Additional best practices include using projector technology or using screen sharing technology for resolving technology-related issues. MCOs also offer designated state officials access to the plan's Medicaid portal to look up specific Medicaid transactions. MCOs also maintain compliance with HIPAA and other privacy standards and do not, as a standard practice, permit direct data access to unauthorized personnel, visitors, or contractors.

## c. How MCOs could use Ohio health information exchanges and/or other real-time data to deliver services and improve health outcomes. Data elements the MCO can share and the format of the data. Extent of current utilization of a health information exchange by the MCO and network of providers. Ideas for how to work with other MCOs to standardize the approach to data-sharing.

MCO digital platforms have evolved to include a personal health record electronic application through which Medicaid members, providers, and authorized care group participants can maintain and manage health information in a private, secure, and confidential environment. Sharing integrated electronic health record details, social determinants of health (SDOH) data, care plan data, and claims data in a secure manner, with the approved users, supports the expansion of interoperability and improves the overall care management process.

### Utility of Health Information Exchanges and Real-Time Data

Currently, MCO care managers who are connected to the Ohio health information exchange (HIE), e.g., CliniSync and HealthBridge, have access to Ohio HIE data, such as test and lab results, X-rays, medication lists, and other electronically captured data. An MCO's care manager can use this data to support continuity of care efforts, address members' gaps in care, and improve member outcomes. MCOs using this data can apply a number of data filters, such as ADT date, care goal status, and other features to help the care manager know when to reach out to a member or to contact individual providers. Additionally, MCOs can leverage HIE data for use with MCO technology applications. For example, population health technology applications can now be used to identify member health risk factors and SDOH indicators. These applications alert care managers regarding gaps in services and can be used to populate dashboards that are used to monitor member outcomes and related metrics.

## Shareable Data Elements and Data Format

MCOs are currently supporting extensible markup language, health level seven (HL7), and proprietary formats. MCOs have plans to deliver Fast Healthcare Interoperability Resources upon receipt of the final decisions and deadline imposed by the Centers for Medicare & Medicaid Services. In partnership with companies like EqualityHealth, a leading clinical and population health platform company, some MCOs have developed an ADT data engine which, using sophisticated proprietary algorithms, parses, organizes, and summarizes ADT records into clear, easily consumed event records and reports. These types of applications include the following attributes:

- Multiple unique HIE connections
- Active HIE file exchanges in several states
- Processing multiple incoming continuity of care, ADT, observation result, documentation message, and gaps in care daily files
- Collaboration with national electronic medical record vendors

This data can be shared in real time across clinical and care management technology platforms and population health platforms, which then supports providers in closing member gaps in care and MCO Quality Management teams as they focus on HEDIS-based quality metrics. MCOs are also using the data referenced previously to develop extensive informatics models and to develop big-data repositories, where the various analytical functions are being used provide trends, clinical and financial risks, and other population-level insights.

## Current HIE Utilization

MCOs are using population health technology applications to aggregate data from multiple internal and external systems, including medical, behavioral, and pharmacy claims, data analytics, cost trends and HEDIS data, lab results, ADT events from state or regional health information exchanges, individual hospital systems, and electronic health records. They use this data in a number of ways, including the following:

- When a member goes to an emergency department (ED) or is admitted, MCOs can receive near real-time ADT data through available electronic population health management platforms. This data is available through secure notifications from a connection to the local HIE through the electronic population health management platform and is regularly shared with members' primary care providers (PCPs). This data is also being used to monitor regional trends for high-risk populations to target zone-specific outreach through community-based health resources.
- MCO Utilization Management (UM) departments use HIE-based data to populate dashboards that are used to monitor utilization-related data reports and review trends. During interdisciplinary care team rounds, the trends in these reports can be reviewed by the MCO's medical leadership and care teams. These UM performance dashboards can also be used to identify members who are utilizing a significant number of services and to engage care teams to outreach to these members to coordinate immediate interventions.
- MCOs can also use HIE-related ED encounters with pregnancy-related diagnoses to identify pregnant members and to enroll them in community-based care management programs.
- MCOs are also using near real-time ADT health information exchange data to improve the continuity of care between hospitals and PCPs by gathering and sharing critical member information that can inform care decisions and improve outcomes.
- Some MCO value-based provider payment arrangements are leveraging population health technology applications to support medical homes and community-based clinics, thereby improving health outcomes while reducing cost to meet value-based service contract targets. These population health management tools support linkage between health care providers, MCOs, and community agencies to share member-specific actionable information to support collaboration, coordination, and management of members' health and health care needs.

### MCO Collaboration and Data Sharing

The primary way to standardize an approach to data sharing is to develop common methods and formats for assessing data quality. These methods could address issues such as the file formats providers use to submit data and support for HEDIS, National Committee for Quality Assurance, and other accreditation data requirements.

## d. Best practices for MCO integration of the MCO's internal systems and incorporation of data from contracted vendors

The best practices associated with MCO data integration and contracted vendor data address contracting and vendor engagement, connectivity, procurement, infrastructure and transmission security, and business and technical requirements. For example, when adding a new vendor, MCOs will commonly administer a standard vendor assessment protocol to align the vendor systems with the MCO's technology systems across the member services, finance, provider services, enrollment, claims processing, encounter, and reporting functions.

Standardized data formats, such as XML and HL7, are regularly used by MCOs and vendors, and interoperability practices should be supported by all stakeholders. Currently, several MCO clinical and population health initiatives are capturing ADT data that can be used to parse, organize, and summarize this data into easily consumed event records and reports.

This data can then be shared in real time with clinical and care management applications to support member health outcomes. MCOs are also collecting vendor data, such as dental, vision, pharmaceutical, laboratory, radiology, and mammogram data, which is being used by population health applications to support closing members' gaps in care, meet HEDIS quality measures, and support other value-based metrics.

Standard practices associated with the collection and processing of this data include receiving timely eligibility, encounter data, and case claims data. Applicable data is then validated and passed to the State in a standard format, which can be used for rate-setting purposes.

## e. Considerations that would impact an MCO's ability or plans to apply real-time eligibility updates

MCOs' current eligibility best practices require accessing member eligibility information through a state's web-based portal and downloading and processing a daily batch file from a state or from a state's enrollment vendor. MCOs use the data in this member eligibility file to support real-time eligibility verification, a member's PCP assignment, and management of a member's term, waiver type, and benefit coverage levels. MCOs also use this data to support the logic necessary to coordinate load balancing and capitation reconciliation. This eligibility file is also shared with an MCO's contracted vendors.

## f. How MCOs might use data and systems to improve the accuracy and timeliness of individuals' eligibility and demographic information, including when an individual's eligibility is pending redetermination

The accuracy, timeliness, and completeness of member data is critical to the overall program's success. Changes in a member's eligibility can impact continuity of care. MCOs commonly use validated and consistent processes for tracking changes in member eligibility, including review of monthly HIPAA-compliant benefit enrollment and maintenance (834) transactions to process and reconcile enrollment data as well as employing standard, documented, and approved processes and procedures for receiving and processing enrollment data.

MCOs evaluate the timely processing of member data against a state's technical specifications criteria and resolve member enrollment changes electronically on a daily and/or monthly basis by taking the following actions:

- Resolving 834 change files in a standard 24-hour business day
- Reconciling member eligibility information between the 834 file and the membership files in the MCO's electronic claims management system, including notifying the state agency in a timely manner when there are changes to the member's circumstances that may affect the member's eligibility (including changes in the member's residence, such as out-of-state claims, or the death of the member)
- Identifying, researching, reconciling, and validating exceptions; making appropriate updates in the MCO's electronic claims management system; and notifying the state agency, as required
- Notifying Member Retention teams to make outreach calls prior to the member's recertification date to remind the member of their disenrollment date, to help the member maintain continuity in their care, and to help avoid a disruption in the member's covered services

## g. Existing data, other than claims data, that could be used to inform population strategy

In addition to claims data, MCO population strategy best practices include collecting, validating, and analyzing clinical data, financial data, SDOH data, and operational data to create actionable analytics that identify and address health disparities in at-risk populations. For example, a dashboard could be developed, based on ADT data, to identify disparities around members who frequent EDs.

The following measures, collected in a HIPAA-compliant fashion and upon receiving member consent when appropriate, can be used to develop a risk model and identify members who are at elevated risk and may need additional resources from the health plan: specific behavioral health disorders, opioid use, physical/sexual/psychological abuse, self-harm claims, comorbidities, risk stratification score, engaged in care management, PCP assignment, frequency of changing PCP over the course of a year, total medical spend, ED utilization, pregnancy, sexually transmitted disease diagnoses, household opioid use, and household physical/sexual/psychological abuse.

MCOs are also considering methods for collecting and analyzing non-claims-based SDOH data to inform population health strategies. For example, by collecting data about the member's employment status, social supports, and access to housing and community resources, MCOs can partner with providers and other community resources to flag these issues and incorporate this data into the member's care management plan and related activities.

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**Creating Greater Confidence in the System through Transparency and Accountability**

**22. General feedback —** What other information should ODM consider as we take the next steps to achieve the goals for Ohio's Medicaid managed care program?

Aetna commends the Ohio Department of Medicaid's (ODM) purposeful, comprehensive, and inclusive approach to **Request for Information (RFI) No. 1** and **RFI 2. RFI No. 2's** detailed information and questions provide insight and direction into ODM's approach and goals for the State's Medicaid managed care program. We appreciate the opportunity to respond and offer the following information for consideration as part of next steps in this process:

- **Administrative simplification:** Aetna recommends administrative simplification as much as possible with the proposed implementation of multiple complex new components into the Medicaid managed care program. These components include the adoption of a single pharmacy benefit manager; the utilization of an administrative services organization responsible for children involved in multiple state systems or with other complex behavioral health needs; the introduction of a fiscal intermediary to serve as a single point of entry for all provider claims and prior authorization requests; and the centralization of all provider credentialing at ODM. We encourage ODM to develop and communicate an overall strategy for the implementation of these new components based on best practices and successful outcomes in other states and to maintain focus on operating efficiently, ensuring timeliness of data and reducing the risk of fragmentation leading to member confusion.
- **Data management:** Aetna recommends streamlining the data sources used by managed care organizations (MCOs), providers, and ODM's new vendor partners to measure health outcomes and the effectiveness of the Medicaid managed care program, using a common reporting structure. This recommendation aligns with the state's initiative to achieve "transparency of clinical, program, and financial data," as described in **ODM's annual report published in August 2019**.
- **Schedule of contract amendments:** Aetna recommends changing the schedule of contract amendments from semiannual to annual to reduce administrative requirements on ODM, providers, and MCOs. This change would enable MCOs to focus their resources on emphasizing the personalized care experience, improving wellness and health outcomes, and supporting providers in better patient care.
- **Request for Application (RFA) format:** Aetna recommends the RFA be similar in format to **RFI No. 2**, enabling participating MCOs to provide detailed narrative responses that describe the depth and breadth of their experience, expertise, and alignment with ODM's goals for the Medicaid managed care program in Ohio. We recognize the value of the use of data- and outcomes-focused questions in a previous procurement, but we also believe context is essential to describing an MCO's qualifications and capabilities for serving the people of Ohio.

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**Creating Greater Confidence in the System through Transparency and Accountability**

**23. Economic Considerations –** The strength of the economy has a countercyclical impact on a state's Medicaid program. Please describe the strategies an MCO might employ to address the negative budgetary effects of an economic downturn, while maintaining a person-centered and effective delivery of care model.

A managed care organization's (MCO) strategies to address the negative budgetary effects of an economic downturn might focus on the following components: maintaining provider network adequacy, collaborating with providers to meet the members' needs, and utilizing non-traditional providers and alternative health care resources to support a person-centered and effective delivery model.

## Network Adequacy

An MCO would make sure its provider network has the depth, diversity of services, and geographic coverage to serve its members seamlessly when the number of covered members increases due to factors such as Medicaid expansion. For MCOs, a robust and adequate provider network is the cornerstone of their Medicaid programs. Generally, MCOs are successful in developing and maintaining mature and comprehensive statewide provider networks by listening to providers, being devoted to their members, communities, and system partners, and working collaboratively to develop and implement solutions that address the unique needs of the states they serve. Strong community relationships with providers, integrated network analysis and recruitment processes, and a high-touch model of network management will assist an MCO in ensuring a network sufficient to meet the needs of its Medicaid members. An MCO would continually monitor its network strategies and implement improvements to its processes to ensure timely access to culturally competent primary and specialty care services necessary to promote the state's goals.

## Collaboration with Traditional, Non-traditional, and Alternative Health Care Providers and Resources

An MCO would work with providers and major health systems to review payment methodologies and conduct analyses on the impact of increasing managed care volumes or material case-mix changes. The MCOs will collaborate with providers, health systems, and the Ohio Department of Medicaid to develop solutions for supporting providers in better patient care during times of economic change.

In addition, an MCO will develop extensive on-the-ground partnerships with a variety of community-based organizations and other non-traditional providers that provide traditional and wraparound services for its members. Having these extensive local partnerships in place extends the reach of an MCO's traditional provider network whenever needed. MCOs will also provide member services such as face-to-face meetings by optimizing their organizational resources—for example, using licensed clinical social workers or community health workers providing services typically covered by a clinical care manager (i.e., registered nurse). Furthermore, an MCO can leverage its network of non-traditional providers such as chiropractors, acupuncturists, reflexologists, and massage therapists to practice top-of-license and ensure a personalized care experience for members.

MCOs continually assess their entire network's ability to meet future projections of member needs through various meetings, data and reports, and stakeholder feedback. Provider Services staff and leadership typically meet regularly to review network adequacy and access to care and identify any emerging member and system needs.

This analysis involves the following interventions:

- Ongoing active evaluation of network additions and terminations, including identifying trends or particular providers through Provider Services and Medical Management/Care Management teams

- Review of physician panel size and capacity to serve challenging members
- Appointment access standard reviews in alignment with contractual requirements
- Results of annual provider satisfaction surveys that incorporate feedback from network participants on satisfaction of available providers
- Evaluation of Consumer Assessment of Healthcare Providers and Systems survey results that evaluate member satisfaction with access to care
- Use of telemedicine if appropriate and as available, especially in support of access in rural areas

This proactive approach would allow an MCO to anticipate and make sure its network is adequate and able to meet access standards, even in the event of an unexpected and significant increase in enrollment.

**Interview**

**24. Opportunity for Interview –** Indicate in your Response if your entity/organization would like the opportunity for an interview with ODM to discuss the answers you have provided in Response to the RFI. Attendance at an interview will neither increase nor decrease any Respondent's chance of being awarded a contract from a subsequent solicitation by ODM. If your entity desires the opportunity for an interview, indicate so in your Response and include the following information:

a. Name of entity or organization.

b. Entity Type.

c. Point of contact, including name, telephone number, and email address, for the purpose of scheduling the interview.

d. Name, title and employer of proposed attendees to the interview, including any contracted lobbyists or consultants.

e. Brief description of the topic or topics in the entity or organization's RFI response that the entity or organization would propose to address in the interview.

ODM reserves the right to request that contracted lobbyists and/or consultants not attend the interview meeting with ODM. ODM will in its sole discretion grant or deny an interview proposal based upon its review of the RFI response provided by the entity or organization. ODM may issue a request for written clarifications in lieu of an interview. Interviews for the purpose of "general presentations" or "sales pitches" will not be granted.

Aetna would welcome the opportunity to interview with ODM to discuss the answers we have provided in the Request for Information. We provide the following information for consideration:

**a. Name of entity or organization:** Aetna Better Health Inc. dba Aetna Better Health® of Ohio

**b. Entity type:** Managed care organization (MCO)

**c. Point of contact:**
- Maureen Pero
- Phone: 937-776-2949
- Email: mburfp@aetna.com
  (Aetna Medicaid organization's primary communications channel for state solicitations)

**d. Proposed attendees:**
- Tony Solem, chief executive officer, Aetna Better Health of Ohio
- Maureen Pero, vice president, Midwest Region business development, Aetna's national Medicaid organization
- Dr. Tracey Green, vice president, Medicaid personalized health, Aetna's national Medicaid organization
- Dr. Negri, senior clinical solutions behavioral health medical director, Aetna's national Medicaid organization
- Dr. Frank Angotti III, behavioral health medical director, Aetna Better Health of West Virginia
- Josh Boynton, vice president, complex care strategy, Aetna's national Medicaid organization

**e. Proposed topic to discuss in the interview: Question 13,** Services for Children Involved in Multiple State Systems or with Complex Behavioral Health Needs
- We would welcome the opportunity to discuss our evidence-based models and best practices experience serving these populations in other states.
- Proposed points of discussion include the following:
  - Our focus on preventive, family-based services to support children, youth, and families involved with multiple state systems.

  - Our extensive experience in Arizona, where Mercy Care, a health plan administered by the Aetna Medicaid organization, has developed and maintained strong partnerships with the state and delivered successful outcomes through the Meet Me Where I Am program providing intensive wraparound services. The management of physical health and behavioral health services by the health plan for this population has been a key component in Arizona.
  - Our experience in West Virginia, where we have an enhanced partnership with the state serving children with serious emotional disorders through a new waiver implemented January 1, 2020. Additionally, we are early adopters of the Family First Prevention Services Act. We can discuss our approach to implementing these new services.
- Our programs and systems are guided by a team of child welfare experts who understand the resources needed and strategies to work collaboratively with ODM, the Ohio Department of Job and Family Services, the Office of Children Services Transformation, and other state agencies to support stability, build on members' and families' capabilities, and help them achieve their life goals. Our discussion leaders will include the following Aetna experts:
  - Dr. Tracey Green, vice president, Medicaid personalized health
  - Dr. Ann Negri, senior clinical solutions behavioral health medical director
  - Dr. Frank Angotti III, behavioral health medical director, Aetna Better Health West Virginia
  - Josh Boynton, vice president, complex care strategy