Ohio Department of Medicaid

Request for Information

ODMR20210019

Ohio Medicaid Managed Care Program RFI #2

Feedback Regarding Ohio Medicaid's
Future Managed Care Program

AmeriHealth Caritas
Ohio

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March 3, 2020

SUBMITTED VIA EMAIL

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Medicaid Director
Ohio Department of Medicaid
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50 West Town Street
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Columbus, OH 43215
ODM_Procurement@medicaid.ohio.gov

Dear Ms. Corcoran:

AmeriHealth Caritas Ohio appreciates the opportunity to provide a response to the Ohio Medicaid Managed Care Program Request for Information #2 ODMR20210019, regarding Ohio Medicaid's future managed care program. This response includes recommendations and observations based on the experience of AmeriHealth Caritas, which has supported Medicaid populations through statewide managed care contracts for more than 35 years. As a national leader in managed care, AmeriHealth Caritas currently serves more than 5 million members in 12 states and the District of Columbia through Medicaid, Medicare, behavioral health, long-term services and supports, and pharmacy benefit management contracts.

AmeriHealth Caritas is a mission-focused organization. Our mission is simple, yet powerful: We help people get care, stay well, and build healthy communities. We have a special concern for those who are poor, and our service is built on the values of advocacy, care for the poor, compassion, competence, dignity, diversity, hospitality, and stewardship. We focus on person-centered care and services to build healthier communities and make a positive, lasting difference in people's lives.

We look forward to the opportunity to further discuss advancing Medicaid managed care in Ohio, our capabilities, and to demonstrate that care is truly the heart of our work. Please feel free to contact me or my colleague, Mary Pat Sherry, with any additional questions or comments regarding this response. I can be reached at pjakuc@amerihealthcaritas.com or (267) 298-2490 and Mary Pat can be reached at msherry@amerihealthcaritas.com or (215) 514-5320.

Sincerely,

Peter A. Jakuc

Peter A. Jakuc
Senior Vice President & Chief Development Officer
AmeriHealth Caritas

Section V
Content of Response

Delivering the Next
Generation
of Health Care

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Emphasizing a Personalized Care Experience

1. Person-Centered Care

Through the procurement, ODM intends to improve the engagement and experience of individuals and their families as they access care throughout the Medicaid system.

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

The Ohio Department of Medicaid (ODM) can improve the engagement and experience of individuals and their families in accessing care by requiring the use of a person-centered approach in all aspects of care and service provision. This can be accomplished through clearly defining person-centered care and establishing specific expectations for how it should be operationalized. In this regard, AmeriHealth Caritas strongly recommends that expectations for managed care organization (MCO) care coordination be applied equally to Care Coordinating Entities (CCEs) or other organizations that play a part in an individual's care. This will promote a shared vision for member engagement across the entire program and drive a consistent experience for members and their families, regardless of which entity provides their care coordination services.

We recommend that ODM develop MCO and provider requirements for person-centered care based on the following principles:

- Care and treatment plans should be built around member identified goals, which should be documented to support ongoing monitoring and evaluation of progress in relation to the member's goals, and then shared with the member's multidisciplinary team.
- A member's right to determine who may participate in and receive information about their care is paramount. We recommend requiring a standardized member consent form to be used across all MCOs, CCEs, and providers to facilitate a consistent approach in carrying out a member's decision in this regard. Further, to be sure that all individuals serving as a care coordinator understand regulations regarding sharing of information around sensitive topics, such as substance use disorder and HIV treatment, we recommend that this information be part of required training for both MCO and CCE care coordinators.
- Members, their caregivers, and other supportive resources (as desired by the member) should be included in the multidisciplinary team, and in assessment and care planning processes. Their involvement should be documented to support monitoring.
- Members should play a central role in evaluating the quality of the care and services they receive.
- Some members may require intensive support to engage meaningfully in their care. Expectations around care coordination and management staffing should be flexible to accommodate variations in individual needs for support.
- While in-person or one-on-one support is often necessary, many members want and/or need multiple ways to engage and receive support. We recommend offering members a variety of ways to receive information and care coordination support, such as online, e-mail, text, and mobile application.

A shared understanding of person-centered care and related requirements across MCOs, providers, and CCEs will be crucial for improving the member experience and applying person-centered care principles consistently. To accomplish this, we recommend that ODM establish specific requirements for related education and training for all MCO and CCE member-facing staff (such as call center representatives, care coordinators, care managers, and Care Guides) as well as providers. Training should cover what person-centered care is and requirements for providing person-centered care coordination and management, as

well as topics such as cultural competency, avoiding implicit bias, trauma-informed care practices, and Motivational Interviewing.

b. Describe strategies MCOs can use to engage members into wellness activities known to improve health outcomes.

AmeriHealth Caritas uses focused strategies to engage Medicaid members with a wide variety of conditions and needs in wellness activities known to improve outcomes. We tailor our strategies to the specific characteristics and needs of our enrolled population in each market we serve, recognizing that our approach must account for variations in populations enrolled, health status, health disparities, provider and community resource infrastructure, and state priorities.

We recommend a collaborative approach to select key wellness activities that align with state priorities (such as reducing smoking, especially among pregnant women) and designing strategies to be applied across a region or the entire state in order to maximize impact.

AmeriHealth Caritas has found in other markets that some members respond positively to incentives for engaging in wellness activities. We recommend that MCOs be permitted to use incentives flexibly and creatively to motivate and reward member wellness behaviors.

Recognizing the critical role of social determinants on health and wellness, AmeriHealth Caritas offers value-added benefits, where permitted, to address social needs. In our experience, this not only meets a member need, but also models our commitment to their overall well-being. We recommend ODM allow and encourage MCOs to propose and offer value-added services that meet social needs, not just clinical needs. We further recommend that MCOs be permitted to offer different value-added benefits based on individual community needs (such as transportation in Columbus or additional smoking cessation benefits in Appalachian regions) rather than only a single set of value-added benefits statewide.

If CCEs will be responsible for engaging members in wellness activities, we recommend that requirements and expectations for their engagement and process be the same as for MCOs. This will help to ensure a consistent experience and engagement into wellness activities for members, regardless of which entity provides their care coordination. We also recommend developing and requiring a standard method for CCEs and MCOs to document and share their efforts to engage members in wellness activities in order to prevent duplication.

c. Describe 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).

AmeriHealth Caritas successfully leverages a variety of technology solutions to communicate with individuals about wellness activities, benefits, and health care, and overcoming geographic and other barriers, including lack of phone and internet access.

Communicating With Individuals

Across all markets we serve, our Medicaid members — like the general population — increasingly use electronic methods of communication. We have tailored our strategies to accommodate member choice and improve our ability to connect with and engage members. Below, we provide examples of how technology can be leveraged effectively to communicate with individuals about wellness activities, benefits, and health care. We would welcome the opportunity to meet with ODM to discuss in more detail our approach to using technology to engage and communicate with members.

Provide a Range of Communication Options to Improve Member Experience

Web, mobile, and text interactions should all be available to members based on their preferences, including language and technology platform. In addition to in-person, phone, and hard copy communication, these methods offer members options to communicate in the ways and at the times that work best for them. In our experience, a large proportion of Medicaid members are *mobile-first*, meaning that mobile phones are their preferred, primary means of communication. For this reason, we recommend that ODM encourage MCOs to offer tools such as mobile applications and text messaging to members.

We also recommend the use of social media as another avenue for communicating with members. This medium is useful for communicating about topics such as available benefits, how to access health care appropriately, and the importance of participating in wellness activities. MCO-sponsored community events provide an excellent opportunity for members to communicate in person with MCO representatives.

Web-based Technologies Providing Seamless Access to Medicaid Application and Renewal Processes

To provide a more seamless experience, ODM may consider implementing a live chat feature on the State's enrollment site. In addition, ODM could consider *omnichannel* engagement, in which an enrollment agent sees the details of the member's web request and assists them as they proceed through the application and renewal processes.

We recommend that ODM standardize a common set of services so that all individuals receive information from a single *source of truth.* For example, ODM could make a set of redetermination services available that would be used by the State and all Medicaid MCOs. A web service could also be used to update the State's data with changes in member contact information, keeping demographic information synchronized across entities participating in the Medicaid Managed Care program.

Addressing Geographic and Other Barriers

We know from our experience in other states that members in rural areas often experience barriers to communication due to limited internet and phone access. We understand that the State of Ohio has invested heavily in statewide internet connectivity, expanding the ability to use web-based and mobile communication methods. However, connectivity remains limited in some areas, similar to our experience in Pennsylvania and other states with broad connectivity in urban and suburban areas, but more limited rural access. For members with mobile service availability but no phone, MCOs can connect them to SafeLink Wireless®, where available, or provide phones to them where SafeLink Wireless is not available. When phone service is limited or unavailable, or when members prefer to use a computer rather than a phone, MCOs can connect members to resources such as publicly available computers at their local public library.

When phone and internet access are limited, we recommend the use of in-person communication. For example, AmeriHealth Caritas offers in-person communication at our Community Wellness Centers. Other methods of in-person communication include coordinating with local organizations to hold group education sessions; leveraging providers and organizations serving the member as vehicles for communication about the member's health, wellness, and care; and having staff meet one-on-one with members in their homes or at provider offices. We have found Community Health Workers to be an effective method for communicating in person with members about wellness activities, benefits, and health care as well as assisting them to access care and wellness activities.

In rural areas where communication is limited, access to care is also often limited. We recommend a robust role for telehealth services in expanding access in areas with provider shortages or transportation

challenges. For example, some states have removed requirements that both member and provider must be located at Medicaid-enrolled sites. This has allowed MCOs to offer telemonitoring and telemedicine applications that can be accessed from a member's telephone or computer, expanding access to care for conditions such as diabetes and hypertension. Additionally, we understand that Ohio has multiple areas with a shortage of dental providers, including the southeast and central parts of the state. We recommend that the State consider adding teledentistry as a covered Medicaid service to enable MCOs to expand access to these important services.

d. Describe 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 geographic disparities through the use of technology, such as the communication technologies described above to educate and assist members. Telemedicine can be used to overcome geographic barriers, both through direct services provided by a remote provider as well as through supporting local providers to expand their capabilities to fill local access gaps (such as through remote education and support). Telehealth services such as remote monitoring can also overcome geographic barriers, and prevent or reduce the need for members to travel to receive monitoring. In addition, mobile wellness vehicles are often used to bring needed care into communities lacking available providers. Transportation is also an important way to reduce the impact of geographic disparities, such as supplementing non-emergency medical transportation benefits through value-added transportation services.

Providers are uniquely positioned to address the impact of health disparities due to race, ethnicity, and income level. AmeriHealth Caritas supports our providers through a robust program of education and training on health disparities, and key strategies for preventing and addressing them. Based on our experience, we recommend that providers complete training on health disparities due to race, ethnicity, and income level; cultural competency; and engaging members with respect. To reduce provider administrative burden and promote a consistent understanding of these topics, ODM could consider a standardized training curriculum and allow providers to complete the training one time instead of once for each MCO with which they participate. We also recommend that MCOs monitor member complaints and grievances, member surveys, and other feedback related to their experience with providers to identify those that may need additional support to engage in a culturally relevant manner and avoid implicit bias. MCOs can also monitor feedback from Member Advisory Committees and community based organizations to identify individual providers as well as trends to address.

MCOs should implement staff training on topics similar to those described above for providers, as well as similar monitoring strategies. In addition, MCOs should collect and use member and provider race, ethnicity, and language data to connect members with providers of similar cultural backgrounds and languages spoken.

MCOs should identify and implement strategies to address any identified disparities among their members. However, the collective impact of all MCOs working to address the same disparities holds the potential for much greater impact than one MCO working alone. For example, we understand that ODM currently works with the incumbent MCOs on a collaborative initiative to reduce infant mortality. AmeriHealth Caritas believes this is a model that ODM should consider applying to other key disparities in Ohio. A collaborative effort with all MCOs to identify one or more disparities to be targeted program-wide will align efforts, minimize burden on providers, and result in a consistent message for members. Measures should be selected based on the identified disparity and ease of data collection. We recommend use of evidence-based and best practice interventions along with flexibility for MCO innovation and testing promising approaches.

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

AmeriHealth Caritas recognizes that members do not engage when they do not feel understood and respected. This can lead to poor health outcomes and health disparities. Providers should have a minimum level of understanding of how to develop and foster relationships of respect and trust with members across a wide range of cultures and backgrounds to promote active member involvement in care, including willingness to share important information with the provider, provide input on treatment recommendations, and adhere to treatment plans. This requires education and support as well as monitoring to identify when additional support may be needed.

Supporting Providers

We have a strong program for supporting and monitoring our providers in implementing culturally relevant, person-centered care to promote respect, trust, and empathy. In our experience, some of the most important ways MCOs can support providers include:

- Providing education and ongoing opportunities for training and support on cultural competency and person-centered care as well as health disparities (both the general topic as well as specific disparities among the enrolled population) and evidence-based engagement strategies that can impact disparities, such as how to recognize implicit bias. Education and training should include on-demand, online opportunities as well as the availability of continuing medical education credits for participation when possible.
- Incorporating progress on selected health disparities as part of value-based payment arrangements.
- Providing feedback to the provider on performance related to cultural competency, person-centered care, and health disparities. This could include member complaint and grievance information, feedback from care coordination and management staff, and practice-specific data on health disparities and progress addressing them.

We also recommend the implementation of cross-MCO health disparities initiatives aimed at priority areas of disparity with aligned education for providers on effective strategies (such as culturally relevant outreach and engagement) to address the targeted disparities. This would raise provider awareness of disparities and the care delivery strategies needed to effectively address them, as well as incentivize progress in addressing disparities. In addition, MCOs can work collaboratively to support providers to educate their staff as well as members on topics for which there may be misinformation due to social or cultural beliefs, such as vaccination safety.

Monitoring

One key way AmeriHealth Caritas monitors the cultural relevance of provider care delivery and ability to foster trust, respect, and empathy is through member feedback regarding their experience with the provider. In addition to monitoring member complaints and grievances, MCOs can use member surveys as well as one-on-one feedback from care coordination and management staff interacting with the provider and member to inform them.

Additionally, we recommend monitoring provider performance on selected outcomes by subpopulation. Measuring at the subpopulation level can shed light on the effectiveness of strategies to address and reduce disparities and identify opportunities to provide additional support to members, providers, and staff.

Managed Care Structure
Questions 2 Through 5

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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.

AmeriHealth Caritas is interested in participating in Ohio's redesigned managed care program. We are committed to providing a network of high-quality providers, strong member services and supports for accessing care and staying healthy, and care coordination and management services that fit Ohio members' needs, whether on a statewide or regional basis.

Our experience in other states has demonstrated that regional awards require careful consideration of several critical factors in order to provide marketplace stability and member choice. These include:

- Regional rate setting, with adequate rates to attract new market entrants and help ensure managed care organization (MCO) viability.
- Selecting an adequate number of plans in each region to provide member choice, while allowing for sufficient membership for each MCO in the region to protect viability.
- An enrollment floor for each MCO in a region to establish critical mass by eligibility group, based on differences in risk and cost among subpopulations in the region.
- Consideration of rate setting of out-of-network costs, particularly for MCOs that do not operate in every region, as members may access care in other regions due to geographic proximity or existing patterns of care. Out-of-network costs are a particular issue for regional MCOs addressing statewide patterns of care. For example, individuals from all regions travel to Columbus to receive cancer care from the James Cancer Hospital at Ohio State. The Cleveland Clinic draws individuals from all over the State for a variety of specialty services that may not be available in all regions. MCOs operating in other regions will have less ability to negotiate contracts with such providers due to lower enrollment volume.
- Consideration of the number of required offices and staff in each office during rate-setting.
- State capacity for oversight and program management of multiple regions and a larger number of MCOs.

AmeriHealth Caritas welcomes the opportunity to discuss our experience with both regional and statewide awards in more detail, such as recommended minimum enrollment levels needed for MCO viability, with the Ohio Department of Medicaid (ODM).

b. Should changes be made to the currently defined MCO geographical regions? If so, what should ODM consider when redefining the regions?

We believe caution is required when changing definitions of already-defined geographic regions. Changes can inadvertently disrupt provider referral and member access patterns established based on existing regions, causing confusion and increasing out-of-network utilization. If ODM opts to modify existing geographical regions, we recommend a process to obtain input from MCOs, providers in all regions, members/advocates, and other stakeholders to evaluate existing patterns of care and the impact of specific changes.

Some important considerations include:

- Meaningful groupings of contiguous counties that reflect existing patterns of care. For example, individuals from all counties contiguous with Franklin County come into the county to access care at Ohio State Wexner Medical Center. Any regional change should maintain Franklin County with all counties contiguous with it.
- Adequate provider distribution across a region. For example, some rural areas have significant provider shortages and, in some cases, certain specialties are not available at all in the region. In such cases, members may have to travel outside the region to receive care. This would present challenges with provider contract negotiation, particularly for an MCO only awarded one rural region.

In addition, we recommend that ODM take into account the number of members in a region and how that may impact the level of enrollment needed by MCOs to sustain viability. We have reviewed current information on Ohio enrollment by region and can make more detailed recommendations to ODM on potential impact as requested.

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?

AmeriHealth Caritas understands the potential benefits of having a single pharmacy benefit manager (PBM) administer pharmacy benefits for all Ohio Medicaid eligible beneficiaries, instead of having each MCO manage these benefits for their respective members. Today, Medicaid MCOs subcontract directly with PBMs and have real-time access to pharmacy data that informs and impacts their clinical programs. It is imperative that MCOs receive electronic pharmacy data daily (preferably in real time) so that they have the information to provide timely, appropriate care management and coordination. MCOs will also need to partner closely with ODM and the new PBM to support and enhance the effectiveness of clinical programs.

The following are recommendations for optimizing the coordination of MCO and pharmacy benefit management clinical programs that enable MCOs to offer pharmacy benefits to improve individual member and overall population health.

Defining Roles and Responsibilities to Preserve the Benefits of Managed Care

Clearly defined roles and responsibilities — along with high levels of communication, collaboration, and coordination between the PBM and MCOs — are imperative to help ensure that these entities are working in concert to foster improved health care outcomes. Once the PBM contract is awarded, AmeriHealth Caritas suggests that ODM consider hosting weekly MCO/PBM joint operating committee meetings during the first six weeks of implementation and monthly thereafter, in order to resolve data exchange or other technical issues that may impact the MCOs and potential concerns about coordinating or aligning clinical programs, processes, and policies. These regular meetings promote efficient, effective program functioning and help to advance the objective of complementary, non-duplicative PBM and MCO clinical programs and the preservation of the benefits of managed care. We recommend each MCO maintain a pharmacist on staff.

Uncoordinated or duplicative programs could also result in higher administrative costs, which may offset savings related to improved utilization and health outcomes. ODM should align PBM and MCO clinical policies, to the extent they currently exist, to promote consistency and simplify administration.

Provider Communication and Education About Clinical Programs

To help providers understand, embrace, and adhere to respective or joint MCO/PBM clinical programs and initiatives, ODM should require close coordination of provider communication, education, and outreach to avoid duplication of efforts. If providers are contacted by both programs about the same or similar programs, it could cause confusion or frustration.

We also recommend that ODM, MCOs, and the PBM collaborate with the provider community, including behavioral health or other appropriate provider associations, on developing ways to optimize communication about pharmacy benefits and MCO/PBM clinical programs. Provider advisory committee meetings could be a vehicle for informing communication strategies.

ODM should promote coordinated policies and education to MCO contracted providers and members, so they know who to call when there is an issue with getting a prescription filled. For example, if an MCO contracted provider prescribes a drug but it is denied by the PBM, the problem resolution process needs to be clearly defined regarding when to call the PBM versus the MCO. To address cases in which the provider or member calls the wrong entity, ODM should establish warm transfer protocols between the PBM and MCOs.

Member Communication and Education

As with provider communication and education, ODM should define PBM and MCO responsibility to educate the members about which entity to contact for what purpose. It could be confusing to a member if the PBM is administering clinical programs that overlap with MCO care management activities.

Performance Standards and Incentives

We recommend the following strategies related to pharmacy benefit performance standards and incentives:

- The PBM and MCOs, as appropriate, should use standard metrics to determine the quality of pharmacy services. Measures that deal with safe opioid prescribing should be implemented immediately.

- ODM should promote alternative payment models/value-based payment (APM/VBP) agreements with pharmacies and prescribers. These APMs should incentivize pharmacies, primary care clinicians, and other providers on the continuum to provide coordinated, high-quality care for Medicaid members, especially those with complex needs. Additionally, these APMs should be used to develop a high-quality, statewide network of pharmacies.
- ODM's PBM performance standards should be designed to prevent unintended consequences for MCOs or impediments to their ability to meet their assigned service level agreements.

Additional Recommendations

AmeriHealth Caritas recommends the following additional strategies:

- ODM should allow MCO input and agreement on the formulary and on the suite of front-end cost-avoidance edits.
- The PBM should be required to share information with the MCOs on program integrity schemes and patterns monthly (or more frequently depending on the scope of the potential fraud).
- ODM should support use of health information exchanges to push out information to pharmacies that are part of collaborative care agreements.
- Pharmacy benefit management should be designed such that members with substance use disorder and mental illness are encouraged to see their primary place of service for medication administration. This will encourage continuity in relationships and medication adherence.
- Quality improvement projects should include practicing pharmacists from various locations across the State and in different practice settings to gain a broad perspective.
- Care teams should include pharmacy staff from both the MCOs and the PBM. The PBM contract should require active collaboration with MCO care teams as needed or requested.

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

We recommend ODM, the PBM, MCOs, and any fiscal intermediary work collaboratively to review medical policy related to clinician-administered drugs so that approvals and denials are integrated and aligned between these entities. Each entity should share best practices and lessons learned to inform policy discussions. Further, policy for handling these claims for MCO-enrolled providers and members should be mutually agreed upon, documented, and communicated to clinicians prior to implementation so that claims are consistently adjudicated according to policy. ODM contract monitors should review and compare PBM and fiscal intermediary claims data to validate that all parties adhere to the agreed-upon policy.

To help prevent provider frustration, the PBM, MCOs, and any fiscal intermediary should coordinate and align their communication to MCO contracted providers so that they know who to contact if an MCO contracted clinician administers a drug and the claim is denied. The PBM, MCOs, and any fiscal intermediary should publish issue resolution policies for these types of denied claims.

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

Below, we highlight best practices that, in our experience, are important for successful MCO exchange and integration of pharmacy data with a PBM.

Require Fully Interoperable Systems

In order to effectively implement a comprehensive and integrated health care delivery system (including physical health, behavioral health, and pharmacy health programs), as well as to meet managed care

coordination requirements, data exchange between the PBM and MCO should be near-real-time to optimize care coordination, care management, and utilization management. We recommend MCOs have direct access to the PBM system for real-time information. For example, MCOs will need the PBM to verify prescriptions are filled and refilled to help support medication therapy management, opioid use programs, patient compliance, and other clinical or care management activities.

AmeriHealth Caritas recommends regular joint operating committee meetings among ODM, the MCOs, and the PBM to discuss roles and responsibilities; data exchange and communication protocols; issue tracking and management processes and procedures; coordinating vendor-to-vendor testing; and collaborating on pharmacy programs, policies, and initiatives that impact managed care members. We recommend meeting with higher frequency (such as weekly) in the period just before and for the first few months following implementation, then possibly monthly to quarterly as operations progress. Further, ODM should develop its implementation and readiness review schedule, including testing the data exchange between the MCOs and the PBM (to allow ample time for coding corrections and retesting if necessary) and culminating in full readiness as of go-live.

Ongoing, ODM should provide MCOs with sufficient advance notification of planned PBM system changes that impact the pharmacy files they send to the MCOs so that the MCOs, in turn, have sufficient time to make and test necessary changes in their respective systems.

Require a PBM Rapid Response Team

ODM should require the PBM to implement a rapid response team and hotline, establishing problem response processes and escalation protocols for error resolution to promptly address pharmacy data exchange and integration issues.

Implement PBM Performance Measures that Support MCO-Related Activities

ODM should establish data exchange performance measures for timely and accurate data exchanges, so that any downstream MCO processes for which pharmacy data is dependent (such as utilization and care management programs) are not adversely impacted by delays in data receipt. ODM should also explore implementing performance measures for both the PBM and MCOs regarding coordination and cooperation.

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.

AmeriHealth Caritas has no suggestions on this topic at this time.

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.

Barriers and Proposed Solutions to Implementing a Fiscal Intermediary Model

AmeriHealth Caritas understands and acknowledges the need to streamline Medicaid managed care processes in order to improve consistency and reduce both provider and state Medicaid agency administrative burden. In our experience, there are numerous strategies that ODM, contracted MCOs, and providers can develop collaboratively to achieve this goal, such as:

- Development and use of a common prior authorization form across all MCOs.
- Requirements for MCOs to offer online claims submission so that providers do not have to go through a clearinghouse.
- Development of a page on the ODM website with links to each MCO's provider portal for online claims submission.
- Standardized medical policy and billing guidelines.
- Requirements for MCOs to use National Correct Coding Initiative (NCCI) edits, which represent the industry standard.
- Requirements for MCOs to submit encounter data that is reconciled to payment information.

In our experience, such collaboratively developed streamlining approaches can address ODM and provider concerns about consistency and administrative burden without introducing the added complexity and cost and potential unintended consequences of a fiscal intermediary model. AmeriHealth Caritas welcomes the opportunity to discuss such approaches in more detail should ODM have an interest in exploring those options prior to introducing a major system change. However, we also offer the following suggestions for addressing the barriers presented by a fiscal intermediary model and look forward to working with ODM, other MCOs, and additional stakeholders (including provider associations, large groups, and individual providers) as appropriate, to foster a smooth implementation of this program change.

Potential Barriers and Proposed Solutions: MCO Perspective

In this section we present potential barriers to implementing a fiscal intermediary model from an MCO perspective, along with proposed solutions to overcome these barriers.

Confusion About MCO and Fiscal Intermediary Roles and Responsibilities

Barrier — An absence of clearly defined and understood fiscal intermediary versus MCO roles and responsibilities could cause system, data exchange, and communication issues that unintentionally add to provider, ODM, and MCO administrative burden.

Solutions — ODM should define in detail which entity (fiscal intermediary or MCO) is responsible for specific roles, such as educating providers on clean claim submission and problems with claims that the fiscal intermediary rejects, communicating with providers when a prior authorization is denied, and addressing complaints and appeals related to fiscal intermediary decisions. Clear protocols should be established for how each entity should handle misdirected member and provider calls and complaints. Both MCO and fiscal intermediary contracts should clearly delineate all roles and responsibilities; processes to facilitate collaboration, cooperation, and data sharing; handling of grievances and appeals; and performance standards.

Risks Associated with Major System Change

Barrier — Transitioning from the current MCO processes to a single fiscal intermediary represents a significant change for ODM, MCOs, and providers and introduces multiple risks that must be effectively addressed to continue smooth program functioning and avoid unnecessary cost or administrative burden.

Solutions — ODM should review MCOs' existing cost containment and quality strategies to determine whether they would be adversely impacted by the new fiscal intermediary model. Likewise, the agency should meet with a wide range of providers to identify impact.

AmeriHealth Caritas recommends regular joint operating committee meetings among ODM, the MCOs, and the fiscal intermediary to discuss issues, coordinate vendor-to-vendor testing, and collaborate on solutions. We recommend meeting with higher frequency (for example, weekly) during the lead-up to implementation and for the first few months following go-live, then monthly to quarterly as operations progress. Further, ODM should build readiness review testing of data exchange methods with the MCOs and fiscal intermediary into the implementation schedule, in a way that allows ample time for corrections and retesting if necessary and to reach for full readiness as of go-live.

We also recommend ODM hold individual meetings with MCOs and the fiscal intermediary, especially at the beginning, to allow frank discussion of more sensitive, MCO- or fiscal intermediary-specific topics that may not be appropriate for a joint meeting.

Additionally, appropriate and adequate ODM staff should be assigned to monitor and address issues.

Unintended Delays in Claims Processing and Payments Due to Multiple Data Exchange Needs

Barriers — Our understanding of the described model is that all claims will be submitted to the fiscal intermediary and go through front-end Strategic National Implementation Process (SNIP) edits. The fiscal intermediary will send claims that pass SNIP edits to the MCOs. Delays in receiving files from the fiscal intermediary will impede MCO ability to further process claims timely and result in slower adjudication (pay/deny/suspend for further review) and payment turnaround, resulting in the unintended consequence of MCOs not meeting their service level agreements and ODM imposing liquidated damages.

Unless appropriate processes are established, MCOs will not know that providers have submitted claims to the fiscal intermediary that did not pass the front-end edits and, therefore, will not be able to assist providers who have questions about those rejected claims. If the MCOs are required to process paper claims, as they do today, it could cause confusion among providers as they will need to potentially send claims to two different clearinghouses as well as check two different systems for claim status, depending on how the claim was submitted.

Solutions — ODM should set strict performance requirements for the fiscal intermediary to send MCOs claims data (electronic and Medicare crossover) that pass front-end edits daily and provide, at a minimum, daily reports advising MCOs which claims were submitted to the fiscal intermediary and failed the front-end edits. MCO claims processing and payment service level agreements should be based on the time they receive claims from the fiscal intermediary, not from the time the provider submits the claim to the fiscal

intermediary. ODM should closely monitor data exchange issues (e.g., number of files rejected by MCOs due to errors on fiscal intermediary files and vice versa) to prevent payment delays.

Additionally, we recommend ODM require all entities to securely exchange inbound and outbound HIPAA-compliant files and other health information with other Medicaid entities and trading partners through SFTP or a secure VPN.

Critically, MCOs should be able to customize adjudication edits so that they can maintain the ability to effectively and efficiently manage care.

Compromising MCO Ability to Manage Care Effectively

Barriers — The fiscal intermediary prior authorization logic and processes may not be equipped to handle nuanced requests, which risks delay in the member getting needed care and could disrupt MCO ability to have timely peer-to-peer discussions with providers about prior authorization requests, review alternatives, and provide education. Likewise, making the fiscal intermediary responsible for transmission of prior authorization information could impede MCO ability to make exceptions and authorize services that do not technically meet criteria but are essential to effectively managing person-centered care. Such situations include:

- Approving additional inpatient day(s) to find appropriate post-discharge lodging for a homeless member who needs follow-up care but no longer meets inpatient criteria.
- Approving inpatient days for a foster care member with no post-discharge placement, to allow time for the MCO and the child welfare agency to identify a foster family able to take the child and meet their post-discharge needs.

Solutions — ODM should preserve MCO ability to effectively manage care and address unnecessary utilization, control costs, and improve quality health outcomes. MCO utilization management and prior authorization processes are inextricably linked to state and federally required performance improvement plans, quality strategies, and APMs, as well as cost containment and program integrity strategies. Modifying MCOs' ability to apply these tools must be done with caution to maintain ability to promote appropriate use of services, advance evidence-based care, improve quality, and reduce unnecessary costs.

As with claims processing, we recommend regular joint operating committee meetings to discuss prior authorization; establish roles and responsibilities; determine appropriate standards by which prior authorization criteria will be determined by the ODM and fiscal intermediary versus which criteria the MCOs could recommend or customize; develop a standardized prior authorization request form that provides MCOs with appropriate and adequate information compatible with their current systems so they accurately adjudicate claims and update other records; and document processes and procedures to resolve issues.

Further, we recommend that ODM incorporate member-reported quality as a key area for monitoring both MCO and fiscal intermediary performance. We also recommend monitoring evidence of collaboration across the fiscal intermediary and MCO for timely sharing of prior authorization data and information. While monitoring process metrics (such as timeliness and accuracy of prior authorization processing) is standard, we recommend emphasizing member outcome metrics, such as those that reflect improvement in utilization and health status and meeting care plan goals.

Complicating MCO and Provider Ability to Comply With MCO-Provider Contract Terms

Barriers — Currently, MCOs have contracts with providers that include claims and prior authorization related roles and responsibilities and performance standards (including those required to meet VBP thresholds). The fiscal intermediary option proposes that information regarding adjudicated claims (paid or denied) and prior authorizations (approved or denied) go back through the fiscal intermediary and then to the provider, rather than permitting the MCO to respond directly to their contracted providers. This

process impacts and inadvertently impedes provider and MCO ability to meet contract terms, such as timely claims filing and payment turnaround times.

Solutions — ODM will need to consider how to amend MCO contracts regarding claims adjudication, prior authorization, provider complaints/appeals processes and timelines, and reporting requirements. MCOs will need to revise their provider contracts to flow down new fiscal intermediary requirements and adjust provisions that could be impacted by delays due to fiscal intermediary activity.

Potential Barriers and Solutions: Provider Perspective

In this section, we present potential barriers to implementing a fiscal intermediary model from a provider perspective and recommended solutions to overcome those barriers.

Delays in Claims, Prior Authorization, and Payment Processing

Barriers — Providers may experience longer claims processing and payment turnaround times due to the increased number of data exchanges between the fiscal intermediary and MCOs. If the MCO is responsible for provider payments but the HIPAA 5010 X12 835 remittance advice transaction (835 file) is coming from the fiscal intermediary, the provider may have new challenges reconciling claims submission with final adjudication status and payment. For example, there could be data exchange issues in which the MCO adjudicates and pays the claim (directly to the provider) and submits the 835 file to the fiscal intermediary, but the fiscal intermediary does not process it accurately or in a timely way, which would cause the 835 file and payments sent by the MCO to be out of sync and difficult to reconcile.

Likewise, if there are delays in the fiscal intermediary transmitting a prior authorization, this will delay the member receiving care, which will further delay final adjudication and payment. There could also be data exchange issues whereby an MCO does not get a prior authorization record but receives a claim, which the MCO may inadvertently deny for lack of authorization.

Solutions — As recommended above, the ODM, the fiscal intermediary, and MCOs should collaborate and agree upon standard processes, policies, procedures, and performance standards for data exchanges, response files, and rapid response claims processing error resolution to mitigate the impact of data exchange issues on providers. We recommend ODM work with MCOs and the fiscal intermediary to establish measures that are a meaningful reflection of the MCO's support of fiscal intermediary processes and requirements and the fiscal intermediary's support of MCO processes and requirements.

Provider Communication and Customer Service Support Confusion

Barriers — Under a fiscal intermediary model, providers may still experience administrative burdens due to confusion about where to find information or seek claims submission help. That is, it may be unclear whether the fiscal intermediary or the MCO is responsible to provide information or assist the provider. For example, providers may be confused about whether to appeal to the fiscal intermediary or the MCO if they disagree with the adjudication/payment/denial of a claim or a prior authorization request denial. This model could cause unintended provider frustration and dissatisfaction.

Solutions — ODM should create a coordinated communication plan that clearly outlines respective roles and responsibilities as they relate to provider communication and customer service. ODM, the fiscal intermediary, and MCOs will need to closely collaborate on roles and responsibilities for developing communication and training material to prevent duplication of effort or mixed messaging. ODM should require that communication about how and where to seek information or assistance is consistent and coordinated across all parties, and that providers know who their primary contacts are for which functions. For example, ODM could create a single web landing page as a starting point for all providers. The landing page would include all the billing and clinical standards and direct providers or their billing agent(s) to the right system for billing and troubleshooting. Additionally, the fiscal intermediary would be a single point of

contact for handling claim submission issues. This single point would then link the case to the appropriate staff (MCO or fiscal intermediary) in real time.

We recommend that ODM consider hosting delivery-system-wide provider meetings across the State that include representatives from the fiscal intermediary and each of the MCOs to help educate providers on the new system design. These meetings should begin prior to implementation and continue quarterly through ongoing operations. The agency should also consider hosting webinars for providers who do not have the time or resources to travel to in-person meetings. The agency should post copies of fiscal intermediary and MCO presentations on their centralized provider website for ease of access.

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.

AmeriHealth Caritas recommends ODM collaborate closely with all MCOs and providers prior to release of the fiscal intermediary procurement opportunity to seek input on how to improve the consistency of provider experience across MCOs and fee-for-service (FFS), while maintaining the benefits of managed care to improve appropriateness of services. Multiple opportunities exist to standardize across MCOs for a more consistent provider experience, such as use of NCCI edits and standardizing medical policy and billing guidelines. Standardizing between MCOs and FFS would require implementation of billing guidelines for all services in FFS, which, in our understanding, do not currently exist across all services. However, it is important to maintain MCO flexibility to use claims processing edits and rules tailored to circumstances that may differ from those in FFS and to address the specific needs and situations the MCO identifies among its particular enrolled population and provider network.

Advantages of Requiring MCOs to Comply With Fee-For-Service Edits and Rules

The following are advantages of having MCOs comply with FFS edits and rules:

- Providers would only have to use one clearinghouse for physical health/behavioral health claims submission, and front-end edits would be consistent for all claims. Should ODM decide not to contract with a fiscal intermediary, it could instead require the MCOs to use standardized SNIP edits to promote consistency and reduction of administrative burden. ODM could also mandate the use of a common set of remittance advice codes and messages so that providers can map from a common set versus adapting to each MCO's unique set.
- Front-end claim edits would be consistent for managed care (behavioral health/physical health) and FFS claims, which would make it easier for provider staff. Providers would only have to contact the fiscal intermediary to resolve claims that were rejected for front-end edits, versus multiple MCOs and the FFS claims processor.

Disadvantages of Requiring MCOs to Comply With Fee-For-Service Edits and Rules

In addition to the barriers highlighted in our response to the previous question, other disadvantages of having MCOs comply with FFS edits and rules include:

- There may be an unintended adverse fiscal impact to the overall Medicaid program, as managed care efficiencies may be diluted if MCOs have to follow FFS rules.
- MCOs must rely on the fiscal intermediary to react quickly to adapt to emergent situations that require more expansive or restrictive editing, such as expanding covered services, eligibility during a natural disaster or public health emergency, or adding new edits/restrictions when a new fraud scheme is identified.

- Depending on the type of claim edit suite, ODM may need to develop daily file exchanges with the MCOs to apply the edits to the pre-adjusted claims in a consistent manner. The MCOs may need to alter their core claim platform logic to adhere to a universal set of edits and rules.
- Providers' current concerns about unclear coverage policies and billing/payment inconsistencies may not go away, but may instead take a different form, such as confusion about whether to contact the fiscal intermediary or MCO for claims editing questions and getting conflicting answers. See the response to Question 4.a above for suggestions we propose to address these potential situations.

Types of Edits and Rules That MCOs Should Determine and Rationale

A key consideration in determining the types of edits and rules that MCOs should use is that clinical edits used by MCOs are proprietary. While opportunities exist to standardize medical policy, we strongly recommend maintaining MCO ability to select the clinical edit sets they use.

If the goal is to address differences in what MCOs pay for (which clinical edits help determine), having a fiscal intermediary apply nonclinical edits does not address this variation. However, in our experience, the challenge for providers does not lie in differences in clinical edit sets per se, but rather a lack of consistent medical policies and billing guidance. A potentially more efficient and effective solution is for ODM to determine how medical policy and billing guidelines may be standardized across MCOs. This should be accomplished collaboratively with medical directors from all MCOs.

For other types of edits and rules to be standardized, we also recommend ODM work with MCOs and the fiscal intermediary to reach consensus on which should be determined by the MCOs and which by ODM and the fiscal intermediary. MCOs should provide ODM with best practices and clinical outcome examples that support the rationale for how and when the MCOs should be responsible for determining specific edit and rule types versus ODM/fiscal intermediary. In general, MCOs should be responsible for edits and rules that impact their ability to effectively manage care within their contract performance requirements.

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.

AmeriHealth Caritas supports members' choices of health plans. We believe that competition for members drives MCO innovation, resulting in a better experience for members and greater value for the State. Rather than setting an enrollment cap, we recommend that the State establish an enrollment floor (by region, if ODM awards contracts by region) to promote stability in the marketplace and member choice. Auto-assignment methodology for members who do not select a health plan should accommodate the need for all health plans to have a level of enrollment sufficient to enable meaningful negotiation of provider contracts and to help spread financial risk across the membership. An assurance of adequate enrollment creates an even playing field that encourages non-incumbent MCOs to bid, which in turn spurs incumbents to innovate and improve performance. The resulting competition helps the State advance the program.

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?

To facilitate smooth transitions for members with existing or ongoing care needs, we recommend that the State specify the data elements to be shared, the format, and an expected timeline for data to be shared between health plans. Key data elements that should be shared include historical claims, care

management contacts, and any open authorizations. We have also found that a dedicated point person within each health plan who coordinates transitions and provides supplemental insights has been very helpful in providing for a smooth transition for members. This is also helpful in managing transitions and sharing information between marketplace health plans and Medicaid MCOs when individuals shift from one type of coverage to the other.

We recommend that the State maintain its continuity of care requirements to prevent disruption of ongoing care. To further promote continuity of care and member choice, we recommend prohibiting exclusive contracting so that MCOs are better able to contract with providers to honor member choice and preserve existing and historical member-provider relationships.

As the State prepares to roll out the new program, we recommend using a coordinated approach to stakeholder communication prior to implementation. We have found in our work in other states that an approach that includes the State and the health plans systematically reaching out through multiple media platforms and venues to providers, members, key advocacy groups, and community organizations is critical for arriving at a common understanding of what to expect and who to call with questions during and following the transition process. We recommend that stakeholder outreach begin at least three months prior to implementation.

Stakeholder outreach and communication strategies should be tailored to reflect the different potential audiences (such as members versus caregivers and advocates versus providers), including differences in methods and messaging. These strategies should also be tailored to reflect differences in geographic areas. For example, methods and messaging may be different between rural and urban areas, such as the types of community organizations to engage, use of different types of media, and lack of reliable phone and internet coverage in rural areas.

Improving Wellness and Health Outcomes
Questions 6 Through 11

Delivering the Next
Generation
of Health Care

AmeriHealth Caritas™
Ohio

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).

AmeriHealth Caritas supports the Ohio Department of Medicaid's (ODM's) current efforts to facilitate managed care organization (MCO) collaboration. We offer ODM strategic thought leadership and continue to convene stakeholders nationwide in roundtable discussions to promote cross-system collaboration to build healthy communities, using the population health approach. For example, we hosted a group at our Louisiana Wellness Centers in collaboration with Governing Magazine to publish a white paper titled *Putting the Community Back in Healthcare*, which provides recommendations for state and local governments on the importance of communication in member engagement and the successful application of population health strategies.

To build upon the collaboration in place between MCOs and hospitals, we recommend engaging other stakeholders such as Care Coordinating Entities (CCEs), providers, community-based organizations (CBOs), and member advocacy groups. In line with recent External Quality Review Organization recommendations, we agree that it is essential that providers are engaged in efforts to improve health outcomes from a population health perspective, both regionally and statewide. Bringing different stakeholders together offers the benefit of diverse perspectives, expertise, and resources. Through these state-led, multidisciplinary efforts, ODM has the ability to maximize the collective impact on the issues identified above.

The collaborations should serve as a recurring forum to facilitate the:

- Sharing of population-level data, such as public health data, that can be used to target areas for outreach and services, focusing first on counties with the largest disparities.
- Collecting and sharing race, ethnicity, and language data to support targeted analysis and interventions to address related disparities.
- Identification and resolution of barriers to care, health inequities, and social determinants of health (SDOH).
- Building of CBO partnerships and resource allocation and support across MCOs.
- Development of common metrics and integrated goals that can be used to align value-based arrangements and quality improvement initiatives.
- Sharing of best practices and lessons learned in Ohio and nationally, in a cooperative and transparent (not competitive) manner.

MCO resources and expertise should build upon the efforts and collaborations already in place in the community. Although specific solutions and strategies may vary regionally, we suggest that ODM and MCOs apply consistent approaches and align their focus on targeted clinical domains statewide.

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.

To successfully identify and address SDOH, MCOs must conduct meaningful community-based outreach and collaboration and seek input from community organizations, stakeholders, members, and providers about their respective experiences with prevalent SDOH and the barriers they have identified. Using this input, MCOs can create solutions that develop true partnerships and collaborations with community organizations, instead of causing additional burden to those entities. MCOs should hire and deploy staff who have specific knowledge and experience of the presenting issue to collaborate with the community organizations to address each social determinant.

To identify social needs proactively, we recommend use and capture of z-codes on claims, the use of universal screening tools and health risk assessments among MCOs and providers, and data sharing between providers, MCOs, and ODM. These activities require MCOs to offer providers targeted education, training, and support. MCOs and providers must also have the ability to leverage public health and community data to facilitate recurring analysis and identification of social needs. We encourage ODM to allow MCOs to implement flexible solutions to address SDOH, including value-added services, value-based payments, and in-person outreach.

Through systematic outreach to individuals and organizations that support SDOH needs, communication and referral channels can be established, MCOs can become familiar with the services these organizations offer, and they can explore opportunities to expand their reach. To further address Ohio's SDOH, MCOs should contract with such entities to provide members with services, such as meal services, doula services, peer support, housing, and education and literacy support.

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?

AmeriHealth Caritas has extensive experience in all of our Medicaid markets collaborating with state agencies to support provider efforts to move along the value-based payment (VBP) continuum. We have learned that an essential step in this process is for MCOs and state agencies to seek and incorporate provider and stakeholder feedback in the design and implementation of these programs. We encourage ODM to facilitate recurring opportunities to gain this perspective. Throughout the process and following implementation, members and the community should be engaged to provide their feedback regarding an evaluation of the impact of value-based care strategies.

To help ensure that models are tailored to the needs of Ohio and that goals are achievable, ODM should use historical and regional benchmarking methodologies for guidelines for population-based VBPs. As Ohio's providers note a lack of alignment on quality measurement and data sharing as a significant burden, ODM has an opportunity to identify key measures that address its priority to encourage MCOs and providers to collaborate toward meeting the same goals. Further, we urge ODM to facilitate collaboration among stakeholders to build upon existing multi-payer models, advance additional multi-payer models,

and drive alignment on priority model design aspects. Our experience has shown that strong leadership from dominant stakeholders helps accelerate multi-payer alignment.

MCO Role in Supporting Providers in Value-Based Payment Models

We are highly committed to offering comprehensive education, support, and resources to help providers succeed in their efforts to advance along the VBP continuum. To support providers, MCOs must take the time to fully assess their capabilities and resources.

Based on the results of the assessments, MCOs must also support providers' efforts to build data analysis and effective capabilities and staff development, as needed. The MCO support should be tailored to the individual providers' needs and should be designed to fit into the provider's current workflow. Providers should not be limited to a single approach; for example, we work with providers so that they can leverage both dashboards and detailed data feeds to help understand their VBP performance. Either approach includes ongoing support from AmeriHealth Caritas staff that are experienced in VBP performance and committed to helping providers leverage data to improve their performance in VBP models. We recommend MCOs implement strategies for effective communication, collaboration, and data sharing with providers, tailoring support to provider capabilities.

Specific Alternative Payment Models That ODM Should Promote

In line with the Health Care Payment Learning & Action Network framework, alternative payment models (APMs) should incorporate the following goals:

- Improve the quality of care for patients, as determined by high scores on outcome measures that are meaningful to patients.
- Improve patients' experience of care, including the ease of accessing care.
- Reduce administrative burden for providers and preserve clinical autonomy.
- Reduce cost of care for payers, the community, and the State.
- Improve health equity by reducing health disparities where they exist.

ODM's current initiatives such as the Comprehensive Primary Care (CPC), CPC+, and opioid and maternity focused models are in line with these goals. AmeriHealth Caritas has experience with these models in other markets and fully supports further advancement of these initiatives. We customize our APMs for each market and provider type, which allows us to align overarching program design, provider needs, and the priorities of the state in which we operate. For Ohio, we suggest APMs that address SDOH, such as poverty, food insecurity, housing, member experience, and employment status. APMs should also be designed to help reduce potentially preventable events and improve outcomes on priority health issues, including building upon existing efforts in the State to reduce infant mortality and preterm births, increase healthy behaviors, promote tobacco cessation, and address health care inequities. Specifics of each model should be tailored for the provider type and capabilities, meeting the providers where they are.

We further suggest incorporating program integrity measures/benchmarks in APM agreements to reinforce accurate claims submission, adherence to medical policy, and compliance with State and federal rules and guidelines. Specific metrics should be developed based on collaborative discussions with ODM and other MCOs.

To achieve alignment and facilitate active participation in specific APMs, it is important to have a coordinated effort and seek input and collaboration among state agencies, MCOs, and providers.

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?

To minimize the administrative burden associated with VBP arrangements, AmeriHealth Caritas works with providers to align our VBP offerings with that provider's area of focus and/or with arrangements that they already have in place with other MCOs. We are flexible and accommodate provider needs to truly meet them where they are, build upon the quality and performance measures they currently track, and support the quality goals that they are working toward.

We recommend that providers and MCOs align VBP arrangements statewide on key areas of interest and clinical domains, for example, to improve birth outcomes and/or reduce opioid use. This way, ODM will maximize the collective impact of each MCO's VBP approach. However, MCOs should be given discretion and flexibility on specific quality and performance measures. This discretion allows MCOs to design innovative VBPs that align with a provider's specialty or area of focus and to tailor arrangements according to provider readiness and interest.

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.

AmeriHealth Caritas is fully committed to deploying staff with the expertise and resources to drive provider VBP success. The key to that success is consistent and accurate collection of outcome measures from network providers. Based on our experience, successes, and lessons learned, we recommend that data collection processes incorporate the use of dedicated staff with sufficient expertise to assist provider efforts through both in-person and remote-support modalities. Processes should incorporate claims data reviews, medical record reviews, and reviews of supplemental data submitted by providers (e.g., electronic uploads of quality data). MCOs should use accessible and easy-to-use dashboards that allow providers to track their progress, identify care gaps, and upload quality data.

Examples of outcomes that we collect and use include HEDIS® measures, Centers for Medicare & Medicaid Services Core Measures, hospital admission/readmission data, and compliance with access standards. Other measures states commonly include in their MCO VBP/APM programs include maternity measures, well-child visits, readmission rates, potentially preventable events, behavioral health, preventive care, follow-up care, and diabetic measures.

Outcome data collected should be used by MCOs to identify provider-specific improvement opportunities and to strategically design programs and care models. MCOs can also leverage outcome data to communicate feedback to the state, calculate incentives, and facilitate continuous improvement.

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?

AmeriHealth Caritas supports ODM's shift of focus from care management to population health management strategies. This approach aligns with the model we have successfully implemented in our other Medicaid markets, where we implement activities and initiatives through active collaboration with clinical and community partners. We agree with ODM that the success of a Medicaid managed care program is dependent upon population health management being the cornerstone and primary driver of resource allocation, infrastructure, and processes to improve health outcomes. To that end, we use and recommend the use of:

- Tools and processes that provide for comprehensive data collection, aggregation, and analysis, and offer the ability to identify population health opportunities at the subpopulation level. These include assessment and survey instruments that offer the ability to customize data collection to specific areas of focus, complemented by data marts and analytic software that facilitate analysis of disparate data sets.
- Health plan staff with sufficient bench strength and expertise, including a combination of clinical staff (e.g., RNs, behavioral health clinicians, and pharmacists) augmented by non-clinical staff such as community health workers and peer support specialists. These staff must be sufficiently trained to design and implement effective population health programs that incorporate a combination of outreach approaches and modalities.
- Proactive and collaborative provider and community stakeholder partnerships that inform initiatives and help ensure that strategies are relevant and effective. For example, our Pennsylvania affiliate health plan partners with Metropolitan Area Neighborhood Nutrition Alliance (MANNA) to provide meal service and medical nutrition therapy to targeted, high-utilizing members identified by the care management team. MANNA cooks and delivers nutritious, medically appropriate meals and provides individually tailored nutrition counseling from registered dieticians to members. Our analysis of a sample of engaged members demonstrated a decrease in potentially preventable admissions and a decrease in the number of ED visits, using a six-month pre/post engagement date analysis.

Improvements and lessons learned should be incorporated into MCO operations through *Continuous Quality Improvement* efforts, where results are assessed on a recurring basis and interventions and initiatives are maintained, modified, or enhanced according to findings. However, through our significant population health experience, we know that these efforts cannot be driven by the MCO alone. Quality Improvement and Population Health initiatives should be implemented in collaboration with the appropriate state and community partners in a manner that supports these partners and provides the resources, expertise, and strength necessary to fulfill their respective obligations.

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?

Because we know that overall well-being means more than just physical health care, AmeriHealth Caritas has built a coalition of community partners throughout each state we operate in to help ensure we deliver meaningful and impactful services. It takes a holistic, person-centered approach with all of us working

together to innovate and identify resources. A community focus is critical to finding answers that lead to better solutions and ultimately contribute to the improved health and well-being of the residents. In order to target efforts that are responsive to population health needs at the health-system level, ODM and MCOs must actively seek input from the health systems, Ohio's thought leaders, and Medicaid stakeholders to better understand the support that is needed, the barriers they are facing, and the opportunities they have identified. This collaboration is essential to not only confirm that support offered by MCOs is relevant, but also to avoid fatiguing the member with redundant screenings or interventions.

To appropriately assess member needs and barriers to care and identify opportunities to expand, enhance, or improve care, MCOs must proactively meet with key stakeholders, including the health systems that serve Medicaid beneficiaries. To that end, AmeriHealth Caritas met with several of Ohio's hospital and health systems and learned that they have comprehensive population health and SDOH programs. Initiatives for Ohio must be designed to support and/or enhance the successful activities of stakeholders throughout the State.

In addition to this input and collaboration, to maximize collective impact, efforts should incorporate:

- Evidence-based solutions, such as those promoted by the University of Pennsylvania IMPaCT® model of care and the National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool.
- Integrated data sharing.
- Ongoing provider, member, and community organization feedback for continuous improvement of provider incentives and VBP.
- Alignment and support of ODM's medical home models, such as CPC, CPC+, and patient-centered medical homes.
- Collaboratively developed, value-based programs that are aligned with ODM's population health goals.

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.

AmeriHealth Caritas' experience working in collaboration with state agencies and other community resources to support work-ready individuals seeking and retaining employment has taught us the importance of establishing communication pathways for expedited notification of work-ready members. We are working with community partners to establish key relationships to connect members to employment and other allowable and qualifying activities. Once an MCO receives notification from the state that a member is subject to work requirements, is nonexempt, and unemployed, it should quickly draw on relationships with community partners to support the member and flag the work-ready status so that staff members who come in contact with the member through a routine phone call, at a health fair event, or at a wellness center will have that information to identify and resolve barriers, connect the member to appropriate resources, and provide ongoing reinforcement.

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).

We place members at the center of the planning process and consider their voice and their choice. We recommend that MCOs work with members to identify their goals, addressing barriers to health presented by poverty, food insecurity, housing, and employment, and then building a support structure of CBOs and providers to help them access the education or training that will allow them to meet those goals.

MCOs should advance population health equity and focus on priority SDOH through individual- and community-centric approaches that fully align to ODM's goals. With compassion and respect for dignity, AmeriHealth Caritas encourages members to find their voice and help them articulate their goals and choices. Rounding out this approach, MCOs should work with state programs, CBOs, and other stakeholders to understand regional needs (e.g., careers in demand), available effective programs, and how an MCO might refer, supplement, or provide wrap-around supports to help ensure members meet their goals. In addition, as part of continuous improvement efforts, MCOs should obtain ongoing stakeholder input as they employ flexible and innovative approaches that support members who experience social barriers affecting health.

An example of how AmeriHealth Caritas applies this approach to educate and train individuals for future potential employment opportunities is our Pathways to Work program; with local partners, we offer basic computer and career skills training in a classroom environment, in tandem with on-the-job experience at AmeriHealth Caritas. The program provides participants with overall job readiness and relevant career certification, education, and guidance from experienced mentors about financial literacy and achieving work-life balance. Upon program completion, participants earn a nationally recognized professional certification and receive help connecting with local employment opportunities, including opportunities at our corporate offices and health plans.

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.

Examples of successful approaches to increase access to dental services — particularly where there are network gaps across both rural and urban areas — are highlighted in the following narrative.

Innovative Delivery Models That Increase Access to Dental Services

Innovative delivery models can serve as cost-effective approaches to improve access for historically underserved populations. Increasing utilization of preventive care means that more expensive restorative care can be avoided downstream. In addition to supporting the use of mid-level dental providers and expanding the functions of dental hygienists and other dental auxiliaries, several of AmeriHealth Caritas' affiliate health plans have direct experience with certain innovative approaches to dental care. These include the use of:

Expanded Scope and Setting of Practice for Dental Hygienists — Dental hygienists can increase access to dental care at a lower cost, as they provide clinical services directly to patients, allowing the dentist to focus on restorative care and more complex procedures. Base services they may perform in a dental office setting include patient screening, taking and developing dental x-rays, removing calcium and plaque from teeth, applying sealants and fluoride, and educating patients. Recognizing that Ohio permits dental

hygienists with two or more years of experience and written dentist authorization to provide services outside of the private dental office and without a dentist's supervision, we suggest that MCOs support delivery of these services in the following practice settings, among others:

- Public and private educational institutions.
- Correctional facilities.
- School settings.
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Free and reduced-fee nonprofit health clinics.

Teledentistry — Teledentistry, the use of telehealth systems and methodologies in dentistry, can help provide access to oral health care (primarily diagnostic and preventive) for those who lack transportation or who face cost hurdles to traveling. Providers deliver services in frequently visited sites, such as schools, community centers, and Head Start centers, leading to an increase in appointment compliance. In addition, teledentistry can lessen patient anxiety because the care is delivered in a more familiar setting.

Mobile Dental — We recognize and applaud Ohio's comprehensive mobile dentistry programs, including Ohio State University's Dental Health Outreach Mobile Experience (H.O.M.E.). AmeriHealth Caritas has also had great successes deploying mobile dental vans directly to underserved communities, facilitating access to dental care where the members need it. Combined with appropriate member outreach and provider partnerships, dental vans offer convenient access to preventive care and screenings.

Innovative Provider Incentives and Value-Based Programs — Offering providers incentives to close gaps in care, expand office hours, or otherwise increase access are effective approaches to promoting access to regular dental care.

Complementing these approaches, AmeriHealth Caritas has developed a variety of programs that target specific populations and are designed to increase access to dental care, including dental specialists. These programs incorporate the use of traveling dental providers, emergency department diversion partnerships, workforce development initiatives, and collaborations with FQHCs, RHCs, primary care clinicians, and local dental schools and universities to promote preventive dental services.

MCO and State Collaboration to Address Access Issues

Because the barriers to accessing dental care vary and span both rural and urban areas, in addition to the innovative delivery models described above, we propose that MCOs and ODM work together to:

- Establish relationships with the State dental association and other State programs to expand coverage, educate the Medicaid population on the importance of oral health, and reinforce dental support to special populations, such as members with diabetes, asthma, intellectual and developmental disabilities, and those who are pregnant.
- Work with obstetricians and gynecologists to provide educational materials to pregnant women educating them about the importance of regular dental care during pregnancy. Many women do not seek dental care during pregnancy; however, women with dental disease early in their pregnancy are potentially at risk of preterm delivery. The goal of this is to encourage and engage pregnant members earlier in care.
- Educate the population or members on the implications of oral health care on systemic health. Neglecting important oral health practices can pose serious health risks, particularly for those with physical health issues such as diabetes, asthma, and cardiac problems. By collaborating with providers, members can be educated on appropriate oral health, when to take antibiotics prior to visiting the dentist, and how to avoid illnesses as a result of poor oral health.

- Implement comprehensive community-based member education and outreach programs, such as mobile dental care and school-based programs.
- Provide educational materials to the Medicaid population or members to improve access to dental care, create better relationships between the Medicaid population and dentists, and increase dental health literacy.
- Increase the use of value-based programs to incentivize providers to expand access, lower the cost of care, and improve the quality of care and health outcomes.

Improving access to oral health and dental care in Ohio is going to take more than simply implementing one idea. By combining innovative options with provider support and education, MCOs can assist the State in achieving their goals. We look forward to the opportunity to further discuss advancing dental coverage in Ohio, our capabilities, and experience increasing access to dental services in other Medicaid markets.

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).

Access to non-emergency transportation (NEMT) is an important benefit for the health and wellness of Medicaid members, as it facilitates access to care for those who may not otherwise have reliable or affordable means of transportation. Lack of reliable personal transportation is a pervasive concern and includes challenges that vary locally. To address this, MCOs should offer multifaceted solution options to address members' transportation needs while improving their satisfaction and quality of life.

Improving the Provision of NEMT

Based on AmeriHealth Caritas' wide range of experience and partnerships with state and local transportation entities, we recommend MCOs use all available approaches to address members' diverse NEMT needs. To deliver transportation options that provide access to care when and where it is needed, MCOs should collaborate with ODM, other MCOs, and community partners to develop transportation solutions relevant to and effective for specific local areas and member needs. To promote a personalized care experience, MCOs should discuss transportation needs with members during care management meetings and regular phone calls. MCOs should also solicit input from Member Advisory Committee meetings to improve transportation options and services.

Flexible transportation management approaches ODM should expect from its MCOs include:

- **Providing for quality and safety of drivers** and vehicles through activities (such as pre-implementation audits of transportation vendors) to validate that necessary systems and activities are in place to manage the NEMT services for the Medicaid population, such as that proper driver licensing is current, vehicles are safe, and drivers pass background checks. MCOs should also conduct regular audits to monitor ongoing compliance and performance. Additionally, we recommend that MCOs provide initial and ongoing training to transportation providers on all transportation quality and safety requirements.
- **Reducing wait and transport time** by offering localized solutions that include a comprehensive network capable of meeting the needs of the member population, increasing use of rideshare options (such as Uber or Lyft), and value-based agreements with transportation providers for exceeding performance goals.

- **Monitoring transportation services in real-time** by offering options for members to provide electronic feedback to transportation vendors or directly to the health plan, via mobile devices or by contacting Member Services.
- **Offering flexible options,** such as allowing siblings to be included in transportation to address child care conflicts; friends and family members to provide transportation and receive reimbursement; and multi-stop transportation so that members can stop at the grocery store or pick up prescriptions.

Improving Rural Access

We also recommend the following solutions for improving access, health, and wellness in rural areas by meeting the members where they are:

- Increase the use of telehealth/telemedicine to reduce the need to travel to certain providers.
- Use pop-up clinics in convenient locations to coincide with popular events, such as State and county fairs or other community festivals, and local summer youth camps, such as through the Columbus Recreation and Parks Department.
- Deploy medical and dental mobile clinics in hard-to-reach or health professional shortage areas.
- Use home visits and telemonitoring (where feasible, medically appropriate, and allowed by Medicaid policy) so the member does not need to leave their home to receive treatment.
- Offer members provider appointment assistance and transportation scheduling by contacting member services or by using mobile devices, such as phones, tablets, and laptops.

Improving Care for Children and Adults with Complex Needs Questions 12 Through 16

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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?

AmeriHealth Caritas has experience providing care coordination to children and adults with a wide range of complex needs (including those with multi-system involvement) through multiple models. For example, we are currently working with the state of North Carolina to implement its Medicaid managed care model that will include provision of some care coordination by entities external to the managed care organization (MCO), similar to the Care Coordinating Entities (CCEs) described above. We understand that transitions

between tiers, setting, MCOs, and CCEs present potential continuity of care risks, particularly for high-needs, complex populations. Our following recommendations are informed by our experience with different care coordination models. We welcome the opportunity to meet with the Ohio Department of Medicaid (ODM) and discuss our experience with different care coordination models in other states in more detail.

Roles, Responsibilities, and Collaboration

Entities such as CCEs can vary widely in their qualifications and capabilities to provide care coordination. Not all CCEs will initially have the necessary experience and infrastructure to provide comprehensive, integrated, evidence-based care coordination across the continuum of care. In our experience from other states, many of the CCE types provided as examples in ODM's description only have experience with a limited set of services and/or providers.

For this reason, ODM should determine roles, responsibilities, and collaboration requirements to provide for care access and continuity of care, based on individual CCE qualifications and capabilities. We recommend that ODM establish criteria and requirements for care coordination staff and processes in collaboration with MCOs, CCEs, providers, members, advocates, and other key stakeholders who align with the roles and responsibilities that CCEs may perform. At a minimum, requirements should be the same for MCOs and CCEs for any role or responsibility that might be performed by either the CCE or the MCO. This should include, but may not be limited to, requirements for:

- Care coordination staff qualifications and experience.
- Care coordination staff training topics, frequency, and methods.
- Mandatory care coordination processes (including timeframes, methods, and documentation) such as assessment and care planning, member support for care gap closure, and initiatives focused on reducing potentially preventable events such as emergency department (ED) visits and inpatient admissions and readmissions.

Data exchange (including types of data to exchange, formats, and timeframes) will be critical to facilitating continuity, timeliness, appropriateness of care, and an integrated, whole-person approach. We offer considerations for care coordination data exchange below in response to Question 12d and in response to Question 21.

AmeriHealth Caritas also recommends development of standardized care coordination protocols in alignment with the established criteria CCEs must meet to obtain ODM designation. Establishing standard protocols will promote consistency across MCOs and CCEs, reducing opportunities for confusion among MCO and CCE staff, providers, and members that could result in each MCO and/or CCE using different coordination protocols. Protocols should cover all components of the care coordination and management process, including, but not limited to, transitions between tiers, settings, MCOs, and CCEs.

Delineating Roles and Responsibilities to Leverage Strengths of MCOs and CCEs

Our experience with various care coordination models demonstrates the value of recognizing the respective strengths of MCOs and community entities that provide care coordination. Capitalizing on these strengths to determine appropriate roles and responsibilities will promote efficient, effective program functioning to enhance access and continuity of care and improve outcomes.

MCO Strengths

MCOs offer strengths in several key areas that represent important capabilities to support timely, integrated, and appropriate care. These include, but are not limited to:

- Relationships and experience with a wide range of providers of Medicaid services, such as primary care clinicians and specialty physicians, hospitals and other facility-based providers, pharmacists, ancillary providers, transportation vendors, vision providers, and dental providers. Many MCOs also have relationships and experience with providers of Medicaid services that are not always covered under managed care, such as long-term services and supports, and targeted case management.
- Experience and capabilities related to coordinating and integrating both clinical and non-clinical services across the health and social service continuum.
- A broad knowledge of available non-covered services that members need and access.
- Robust information technology systems and data analytic capabilities for receiving, sharing, integrating, and analyzing comprehensive data and information about members' health care and social determinants of health (SDOH) needs and services.
- Staffing flexibility, such as the ability to quickly adjust staffing to reflect changes in the number of members who need care coordination, member acuity levels, or in the types of staff needed to effectively serve the enrolled population.

CCE Strengths

In our experience, the strengths of CCEs vary widely based on factors such as specialty, provider type, locality, and experience. However, some of the strengths we have often identified among these types of organizations that could be leveraged to benefit members include:

- Strong relationships with the individuals they serve.
- Understanding of the specialized needs of the individuals they serve.
- Knowledge of the health and social service landscape within the local area and other services for which their clients may be eligible.

Minimizing Duplication of Effort Across Entities

As noted above, we believe it will be critical for ODM to establish a clear delineation of roles and responsibilities that align with CCE designation criteria, along with standard coordination protocols that all MCOs and CCEs will use. Involving MCOs, CCEs, providers, members, advocates, and other key stakeholders in the criteria, requirements, and coordination protocol development process will lay the foundation for a program-wide, shared understanding of roles and responsibilities. Building on this foundation, ODM, MCOs, and designated CCEs could work together to provide pre-implementation stakeholder education sessions in various locations around the State. These sessions will provide information about the upcoming change in the care coordination process, the roles and responsibilities of each entity, and how coordination will occur to minimize duplication and meet each member's care coordination needs.

MCO and CCE staff will need in-depth training on roles and responsibilities, including how these may differ based on designation (if there is more than one level), how they may change based on member choice or intensity of needs (such as in a hub-and-spoke model), and established coordination protocols. Providers and members should also receive education on how MCOs and CCEs work together and the roles and responsibilities of each, to prevent confusion and educate all involved about whom to contact and which entity will provide what type of support. We recommend that ODM work with MCOs and CCEs to develop standardized information to be customized for and provided to each audience.

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, for care management agencies, for comprehensive primary care practices?)

Types of CCEs to be Considered for ODM Designation

Not all CCEs currently have the qualifications and capabilities necessary to assume responsibility for all aspects of coordinating and managing care. AmeriHealth Caritas strongly recommends that only those community-based entities able to demonstrate that they meet ODM-established criteria should be considered for ODM designation as a CCE.

Based on our experience with similar models, AmeriHealth Caritas recommends a conservative approach initially when determining which CCEs receive ODM designation to promote a successful launch for all parties. MCOs and CCEs should both have input into the criteria so that considerations and barriers from all sides of the equation are thoroughly explored, and there is a shared understanding of the required qualifications and capabilities necessary. Depending on the variation in CCE qualifications and capabilities, ODM may want to consider more than one level of designation, with criteria for each level tied to specific roles and responsibilities the CCE may assume. This would allow CCEs with greater qualifications and capabilities to take on a larger care coordination role, while those with fewer qualifications and capabilities would still be able to provide care coordination services, albeit in a more limited manner.

In addition, ODM should conduct a readiness review of CCEs (similar to that conducted for MCOs) prior to implementing this model. The readiness review process should include, among other things, CCE testing of data exchange methods with the MCOs, on a timeframe that allows corrections and retesting if necessary to achieve full readiness as of go-live.

How MCO Support to CCEs Might Vary

ODM should establish a set of standard expectations for MCO support based on CCE capabilities, as determined by ODM-established criteria. If there is more than one level of CCE designation, expectations for MCO support should vary by level of designation. Types of support the MCO may provide include:

- Supplementing CCE staffing with MCO staff to develop a multidisciplinary care coordination team for high-risk/high-needs members and those with multiple and/or complex needs. For example, the MCO might support the CCE through providing registered nurse (RN) case manager support to the CCE care coordinator.
- Discharge planning and transition of care support.
- Provision of care and disease management programs to support members with complex needs and chronic conditions.
- Support for identifying and addressing SDOH needs.
- Data analytics to support CCEs that do not have capability to integrate data from multiple external sources in order to complete a holistic analysis of risks and needs.

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?

How MCOs Can Support Individual Care Needs and Remove Barriers

MCOs can provide a range of support for individual care needs and remove barriers to members receiving care coordination from CCEs.

Provide Information

As discussed in more detail in our response to Question 12d below, timely exchange of information is important in meeting individual care needs and delivering services in a timely manner. The MCO should provide information necessary for the CCE to identify and meet the member's care coordination needs. For example, the MCO should provide updated member contact information to promote CCE ability to reach the member. Depending on CCE scope of responsibility, the MCO may need to provide screening and assessment results, care plans, care gaps, medication refill patterns, provider contact information, and SDOH needs.

Support CCE Staff

Team-based care coordination and management is a widely used best practice for supporting the care needs of high-risk individuals and those with multiple and/or complex needs. Depending on CCE staffing and capabilities, the MCO may provide multidisciplinary support to the CCE based on the individual member's needs. For example, the MCO could provide an RN case manager to supplement the CCE's non-licensed care coordinator in supporting a member with a complex clinical condition. The MCO Care Guide could assist the CCE care coordinator to support members who need assistance scheduling appointments, understanding benefits, or connecting to community resources for SDOH needs. The MCO Case Manager or Care Guide can also connect the member to MCO resources, such as case and disease management programs.

In addition, the MCO can leverage its contractual relationships with network providers to promote provider participation in care coordination. For example, the MCO contract can require network providers to participate as requested in care team meetings.

Educate Members on Their Primary Point of Contact for Care Coordination

It will be critical for members to be clear about their primary care coordination point of contact. In instances where a CCE provides the care coordination point of contact for members, MCOs can help members understand their primary care coordination contact by:

- Providing new member orientation that emphasizes person-centered planning to empower the member.
- Capturing the care coordinator's name and contact information in internal MCO systems to provide or share with the member during any contacts.
- Recording contact information for care coordinators in mobile tools and applications.
- Establishing protocols to warm transfer the beneficiary to the CCE care coordinator.

In situations where the MCO provides care management, communication and collaboration between the MCO and CCE will allow CCEs to also have access to the MCO's information to reinforce the primary contact with members.

How ODM Can Measure MCO Support and Responsiveness

AmeriHealth Caritas understands that timely, appropriate MCO support to the CCE is critical in helping ensure effective care coordination to improve outcomes. We recommend that ODM work with MCOs and CCEs to establish measures that are a meaningful reflection of MCO support and responsiveness to CCEs. For example, ODM may consider using surveys to obtain CCE feedback on MCO performance, as well as provider surveys that ask for a provider perspective on the effectiveness of MCO support to CCEs.

d. How could MCOs and CCEs meaningfully exchange data and information to improve care outcomes? What types of data and information should be exchanged?

How Data Could Be Meaningfully Exchanged Between MCOs and CCEs

Regardless of the specific roles and responsibilities of CCEs, MCOs and CCEs will need to exchange a variety of data and information to improve care outcomes. Depending on CCE responsibilities, they may need access to real-time/near–real-time data generated outside their own system in order to provide timely, effective holistic services. Examples of such data include, but are not limited to, information on clinical status, identified risks, and inpatient and ED visits. MCOs will need CCEs to promptly provide data they gather and generate to support timely identification of needs, accuracy of ongoing risk stratification, and appropriate utilization management decisions.

Data Strategies to Facilitate Data and Information Flow Between Entities

Timely, efficient data exchange is a challenge in a model with multiple CCEs and MCOs that do not all share the same data platform. ODM has a strategic opportunity to leverage best practices in design and infrastructure to fully support its model of care and all stakeholders. We highly recommend that ODM leverage existing technology assets and standards to promote the highest level of adoption, participation, and impact. As discussed in more detail in our response to Question 21, using a statewide health information exchange (HIE) is optimal, although interconnected regional exchanges are also an option. A federated model is also recommended, using HL7 with Admission, Discharge, Transfer (ADT) and Continuity of Care Document (CCD) as the core standards. We have worked with multiple HIEs and found that stakeholders are more likely to be successful when the existing standards are used; unfortunately, we have seen the opposite as well. In one state, the lead stakeholder required a non-standard use of the CCD with additional fields. While well intended, the design and implementation took an extended period, had considerable costs, and resulted in low levels of adoption and impact.

While a standards-based approach is highly desirable, there are still challenges with some use cases, such as developing and sharing care plans. Some stakeholders have sought to fulfill this use case through shared portals where information on a member can be updated by all professionals involved in the care team. Our experience is that these portals are ineffective tools, as they require additional steps outside the systems and workflows that CCEs currently use. We believe that new approaches to distributing real-time, actionable information will be more desirable and effective than using portals. Portals today tend to be a better tool for sharing aggregated information to be used for analysis and reporting.

We view the Fast Healthcare Interoperability Resources® (FHIR) standard as the method for exchange of the future that will enable providers and health plans to exchange data. FHIR is built into many of today's electronic health records (EHRs) and is being increasingly adopted by payers. We have developed many use cases in which this method could be used, including allowing members to download their health information in a FHIR format so that they can use vendor applications (e.g., mobile apps) built to ingest the information and provide various health tools as well as for HEDIS® reporting.

We believe the effective exchange of health care information depends on consolidating the existing HIE entities as much as possible. Requiring CCEs to connect to multiple HIEs, often in overlapping service areas, or requiring multiple HIEs to connect and share information with each other is costly, burdensome, and redundant. Where multiple entities are required, they should consider supporting a common set of exchange patterns based on new FHIR application programming interface capabilities.

A consolidated HIE will enable a more meaningful and useful data exchange between systems and align with the current and future value-based landscape. It will serve as a central repository where information can be shared to promote member engagement and electronic exchange of information using certified

electronic health record technology. It will also alleviate administrative burden for CCEs and MCOs, where one connection to the HIE is required to enable data exchange across multiple systems. This information flow will improve care coordination along the continuum of care and can equip CCEs with more timely and actionable data to improve member care.

What Types of Data and Information Should Be Exchanged

Depending on CCE scope of responsibility, the types of data and information the CCE may need from the MCO include:

- Member demographic information.
- Physical and behavioral health diagnoses and status.
- Functional needs and status.
- Screening and assessment results.
- Care plans.
- Care team information.
- Utilization history, including hospitalizations, ED use, and pharmacy.
- Laboratory values.
- Risk scores.
- Care gaps.
- Advance directives.
- Caregiver information and needs.
- Individuals authorized to participate in care.
- SDOH information.

We recognize that ODM intends to carve pharmacy and some behavioral health services out of the benefit package covered by MCOs. MCOs will still need timely, accurate data on these services to appropriately and effectively manage member care. Depending on CCE scope of responsibility, CCEs may also need this data.

Types of data and information generated by the CCE that the MCO may need include:

- Updates to member demographic information.
- Screening and assessment results.
- Care or service plans.
- Monitoring information such as potential changes in condition.
- Updates to caregiver information.

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?

Care Coordination Staffing and Qualifications

To provide quality of care coordination services, CCEs should meet the same staffing and qualification requirements as would be required for MCO staff who perform the same functions. We recommend that ODM establish these requirements in collaboration with CCEs, MCOs, and other key stakeholders to achieve a shared vision across the program for care coordination quality. To bolster CCE staff capabilities and streamline the process for CCEs, we recommend that ODM develop and provide training for CCE staff (in collaboration with MCOs and other stakeholders) that covers topics such as roles, responsibilities,

coordination protocols, person-centered care, cultural competence, and SDOH. Performance metrics should mirror those for MCO care coordination staff and be monitored by ODM to include MCO reporting on CCE performance with respect to the MCO's members they serve.

CCEs may vary in their ability to provide care coordination and members may choose CCE or MCO care coordination (and potentially change from CCE to MCO or vice versa). In addition, since MCOs would remain responsible for providing or arranging for all needed care coordination services for their members, it will be necessary for MCOs to maintain sufficient care coordination staff to serve as a backstop for CCEs that are unable to meet member needs.

Given these factors, AmeriHealth Caritas would caution ODM that prescribing a specific care coordinator/manager to member ratio or caseload size may inadvertently limit the MCO's ability to adjust and personalize member care. First, even in a model in which MCOs provide all care coordination, the ratio of care coordinators/managers to members can vary significantly based on the amount of coordination and contact that specific member situations require. AmeriHealth Caritas does not use a standard ratio in our Medicaid managed care markets, but rather relies on a scoring process. Our weighting system accounts for the frequency of contact and support required for each member’s medical, social, and behavioral health needs based on our integrated model of care. Cumulative panel scores are used to balance care manager caseloads. Second, CCEs may vary in their ability to provide care coordination. Consequently, MCOs will need to provide varying amounts of support, including care coordination/ management staff, depending on the CCE's capabilities to meet each individual member's needs. We recommend allowing MCOs the flexibility to establish and modify staffing ratios as needed to efficiently and effectively serve their enrolled membership and be responsive to member choices of which entity provides care coordination.

Alternative Staffing Arrangements

Team-based care is a best practice and is widely used in Medicaid managed care to more efficiently provide the full range of clinical and nonclinical support a member may need. We recommend requiring that CCE care coordinators function as part of the member's multidisciplinary care team, which would include MCO care coordination/management staff to meet whole-person needs and allow for the efficient use of resources. This will require clear delineation of roles and responsibilities, as well as ODM requirements for CCE staff to participate as part of the multidisciplinary team and share information in a timely way.

A hub-and-spoke model may be useful for high-risk members and those with intensive clinical needs. Under this type of model (such as those implemented in Vermont and Washington for opioid use disorder), intensive needs are addressed at the hub (high-intensity service provided by a specialist), and as the individual progresses and stabilizes, they are transitioned to a spoke (lower-intensity service provided in the community). The hub remains a support to the spoke for expertise and consultation. Using this model, the MCO might be responsible for care management and care coordination for individuals with high-risk/high-needs until they are stable, at which point primary responsibility for care coordination could be transitioned to the CCE, while the MCO remains available to provide input and consultation.

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?

Monitoring Individual Care Coordination/Management Outcomes

AmeriHealth Caritas uses a person-centered approach that supports the member in playing a central role in evaluating the quality of the care coordination and management services they receive. We recommend that ODM incorporate member-reported quality as a key area for monitoring both MCO and CCE care coordination and management performance. Monitoring should include the extent to which the member, as well as their family, caregiver, and other informal supports, are included on the multidisciplinary team and in the assessment and care planning and monitoring processes. We also recommend monitoring evidence of collaboration across the multidisciplinary team, including integrated care planning and timely sharing of data and information. While monitoring process metrics (such as timeliness of outreach and completion of assessments and care plans) is standard, we recommend emphasis on member outcome metrics, such as those that reflect improvement in utilization and health status and meeting care plan goals.

Monitoring Care Coordination/Management Program Outcomes

Collaboration across ODM, MCOs, and CCEs will be critical to the quality and effectiveness of the overall care coordination and management program, particularly as this new model is implemented. We recommend regular joint meetings to discuss issues and collaborate on solutions, with higher frequency (such as weekly) in the period just before and for the first few months following go-live, then perhaps monthly to quarterly as operations progress. We also recommend that ODM hold individual meetings with each MCO and CCE, especially at the beginning, to allow frank discussion of more sensitive MCO- or CCE-specific topics that may not be appropriate for a joint meeting.

In terms of metrics, we recommend looking at aggregate monitoring of the areas of emphasis and monitoring described above for individual outcomes, as well as utilization and cost outcomes for all individuals receiving care coordination/management services. This would apply to both the MCOs and CCEs. We also recommend looking at utilization and cost outcomes for MCO condition-specific case management programs, such as programs that address high-risk pregnancy, diabetes, or substance use disorder.

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?

AmeriHealth Caritas supports and utilizes similar dedicated staff in other markets to provide short-term support to members who need assistance with access, addressing barriers, referrals to community resources, appeals and grievances, and connection to longer-term case management support. This is a proven, efficient way to help members take charge of their health and get the services and supports they need.

Ensuring Care Guides Can Quickly and Effectively Meet Time-Limited Needs

In our experience, quickly and efficiently meeting the types of time-limited needs envisioned by ODM is best done by nonclinical, unlicensed staff. We recommend that Care Guides are hired from the communities they serve and receive initial and ongoing training on topics such as Medicaid, the appeals and grievance process, the managed care program and coordination requirements, the covered populations, the impacts of SDOH, available community resources, cultural competency, and person-centered care.

In some states, MCOs use community health workers (CHWs) to fulfill roles similar to the role described for Care Guides. CHWs help members access and receive adequate care. These supporting staff are familiar

with the community support resources that extend beyond clinical care to address SDOH. CHWs work with members — both in office and community settings — to address barriers to care and treatment, improve health literacy, increase self-sufficiency and their ability to self-manage their care, and help them access the supports they need to fully participate in their care. CHWs help members control chronic illness through outreach, education, counseling, and collaboration with providers. ODM should support MCO efforts to train or certify CHWs to reach disparate populations and include them as an extension of multidisciplinary clinical teams. Requirements for CHW certification should take into account existing certification programs and current availability of certified CHWs within Ohio.

We also recommend mandatory SDOH screening upon enrollment and ongoing. As needs are identified, Care Guides should proactively offer assistance in connecting to community resources. In our experience, it is important that Care Guides follow up on referrals to community resources (*close the loop*) to determine whether the member was able to access the resource.

Monitoring Care Guide Program Quality and Effectiveness

MCO training curricula for Care Guides should be submitted for ODM review to determine that important topics are adequately covered. Staff qualifications and completion of training can be validated upon request. Metrics to monitor program quality and effectiveness may include:

- Percentage of cases resolved to the member's satisfaction.
- Percentage of cases resolved within a specific timeframe or average timeframe to resolution.
- Percentage of referrals closed.
- Rates of complaints and grievances related to Care Guide support.

h. How could each type of care coordination role (MCO, community-based CCE, Care Guide) assist individuals with addressing health-related social needs?

All involved in coordinating member care should take responsibility for identifying health-related social needs — just as they would with new or changed clinical needs — and connecting the member to the appropriate party for support in addressing the need. Roles and responsibilities for identifying and addressing identified social needs should be clearly delineated to prevent confusion on the part of the member, family/caregivers, and providers, and avoid duplication of effort.

We recommend use of a standard SDOH screening tool for both MCOs and CCEs. MCOs should be responsible for completing the screening upon member enrollment and at a regular frequency throughout the member's enrollment. To streamline member experience, CCEs could perform the screening as part of their ongoing care coordination responsibilities. However, in determining whether to require CCEs to screen members for social needs, ODM should consider the current practice of organizations that serve as CCEs in screening for SDOH need, their capacity to add this function if they do not currently perform it, and their ability to transmit screening results to the MCO for inclusion in the member care plan.

Care Guides could support CCEs that do not have the resources or infrastructure to perform this function. Whichever entity makes a referral should be responsible for closing the loop and documenting referral outcomes.

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?

AmeriHealth Caritas recognizes that children and youth who are involved in multiple state systems and children who have other complex behavioral health needs, such as children with multiple placements in the foster care system or a child in a residential treatment facility, would benefit from the more intensive level of care coordination described by ODM. We have extensive experience working in collaboration with state Medicaid and other child-serving agencies and community-based Care Management Entities to provide this level of care coordination and care management. We also have extensive experience providing whole-person care in states in which behavioral health services are carved out into a separate system and we would be happy to discuss these models in more detail during a follow up interview.

We look forward to working with ODM to implement its vision of a seamless delivery system for the children and families of Ohio, and recommend that ODM establish roles, responsibilities, and criteria for participation in this specialized approach that are clear and that lend themselves to establishing and communicating eligibility to the MCOs on a timely basis.

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.

AmeriHealth Caritas has worked extensively with providers to use a High Fidelity Wraparound approach to provide intensive care coordination to children and youth in other markets. The High Fidelity Wraparound approach was developed for children aged 4–17 who have severe emotional, behavioral, or mental health needs, are at risk for out-of-home or institutional placement, or have multi-system involvement. We recommend those populations be targeted for this approach. We recommend that ODM establish eligibility criteria for participation, utilization, and stepdown criteria, acknowledging that provider capacity for both assessment and treatment will vary and will have to be built up over time to meet need.

We recommend that ODM consider limiting the populations of children and youth receiving these services to the categories of highest need and allow populations who have less chronic and/or mild and moderate levels of complexity to be managed by a streamlined and integrated care team under the MCOs.

We also recommend that ODM regularly monitor inter-rater reliability with regard to assessment for eligibility and level of need.

c. What suggestions can you offer to build and expand network capacity to deliver Intensive Care Coordination Using High Fidelity Wraparound?

AmeriHealth Caritas is prepared to work with ODM and the proposed Behavioral Health-Administrative Services Organizations (BH-ASOs) to build additional provider capacity for this intensive care coordination approach, particularly in rural areas of the State, should the State move in this direction. We recommend that ODM consider conducting stakeholder and provider forums to identify barriers providers perceive to

offering and expanding these services. Existing providers can also offer valuable insights into how ODM and its partners can scale up their capacity to serve additional children and youth.

To expand network capacity and ensure that intensive care coordination is available to populations with the greatest need, we recommend ODM consider:

- Limiting the population receiving intensive care coordination to those members with the highest complexity, as recommended in our response to subsection b.
- Expanding the use of telehealth to supplement the delivery of intensive care coordination to members in underserved areas.
- Implementing a phased approach to developing capacity in line with fidelity standards to support referrals once the intake processes are in place.

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?

As noted in our response to question 13, subsection b., AmeriHealth Caritas recommends ODM consider limiting the populations of children and youth receiving these services to the categories of highest need and allow populations who have less chronic and/or mild and moderate levels of complexity to be managed by a streamlined and integrated care team under the MCOs. We recommend that ODM establish eligibility criteria and requirements for this level of care coordination that align with the populations for which the approach was developed.

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?

An effective strategy for workforce development and practice transformation will first acknowledge that providers are in different stages of their development along the continuum of successful transformation and will need support based on their current capabilities. In addition to a streamlined data infrastructure to foster integration and coordination, best practices and lessons learned can be used to develop centers of excellence that will enhance provider capacity to:

- Access real-time, actionable data.
- Construct quality improvement plans.
- Develop person-centered care plans.
- Hire, train, and oversee care coordinators.
- Manage chronically ill members and their comorbidities.
- Conduct population health outreach.
- Create linkages to community-based organizations to address SDOH.

AmeriHealth Caritas has practice transformation processes and staff in place in our current markets and looks forward to establishing these resources for Ohio providers.

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.

AmeriHealth Caritas recommends that ODM collaborate with the MCOs to establish communication channels, identify payment responsibility for covered services and clearly delineate roles and

responsibilities to ensure whole-person, integrated care while reducing the administrative burden placed on providers. Each MCO and BH-ASO should designate a contact person within their respective organization to streamline communication and support close coordination. ODM should establish contractual mechanisms to hold MCOs and the BH-ASO accountable for coordinating on behalf of shared members. Additionally, we recommend that ODM consider establishing memoranda of understanding (MOUs) between the BH-ASO and each MCO outlining service levels, and data sharing and data use agreements.

As noted above, providers need actionable data across geographic areas and member populations to facilitate understanding and manage their patient populations. However, tools to access and effectively use this data often present challenges and create more administrative burden, especially for rural providers.

g. In an ODM-contracted BH-ASO model, what contractual and operational structures should ODM consider to achieve ODM's goals?

AmeriHealth Caritas recommends that ODM establish MOUs to govern carefully defined roles and responsibilities, as well as communication and data exchange paths. Our experience in Pennsylvania has demonstrated that MOUs governing data sharing, joint operating committees, and universal information release forms have helped the State achieve its goals in coordinating services covered by different entities.

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?

Selecting Screening Tools

AmeriHealth Caritas strongly encourages and provides support for primary care clinicians to screen members for behavioral health needs by administering behavioral health and SDOH screens. Our recommended approach to selecting screening tools is to develop consensus around a common screening tool or set of tools that every MCO uses.

While there is variety amongst markets, we have noted success with providers who have been trained, paid, and supported for regular utilization of screenings such as:

- PHQ-2 / PHQ-9 / PHQ-9A for depression severity.
- Columbia Suicide Severity Rating Scale (C-SSRS) for suicide-specific screening.
- DAST and AUDIT for SUD screening in adults and CRAFFT 2.1 for ages 12–21.

AmeriHealth Caritas will work collaboratively with the State and other MCOs to choose the most effective tools that meet the needs of Ohio's population.

In some markets, primary care clinicians have also begun to screen for Adverse Childhood Experiences. We support this practice in the context of a larger trauma-informed health care delivery system and provide education to providers on the strengths and limitations of the information collected.

Screening for Social Determinants of Health

Commonly used evidence-based behavioral health screening tools do not capture unmet needs related to SDOH and a supplemental screening must be used. Screening for SDOH allows the provider and the MCO to work together to support the member.

Supporting Primary Care Clinicians to Complete Screenings

To support primary care clinicians to complete screenings, we recommend that ODM:

- Work with participating MCOs and the BH-ASO to select universal screening tools and collaborate on statewide provider education.
- Allow MCOs to use value-based payment and incentives to promote and support primary care clinician completion of screenings.
- Consider use of universal information release forms to protect privacy while supporting collaboration between providers.
- Work with MCOs and providers to create clear referral pathways to follow-up care. One challenge we often hear from primary care clinicians is that they are unsure of what actions to take if screening identifies a need for further evaluation or treatment.

Data-Sharing

For data-sharing between the primary care clinician and the MCO, we recommend using ICD-10 codes to achieve proper claim coding that captures any conditions identified during screening, as well as building in real-time communication workflow procedures to allow MCOs to support providers in addressing care gaps and unmet needs proactively. This is the current best practice.

We recommend that ODM look for ways to leverage Ohio health information exchanges to connect primary care clinicians' EHRs to the MCOs.

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?

Behavioral Health Crisis Services for Adults, Adolescents, and Children

AmeriHealth Caritas supports offering a full range of behavioral health crisis services for adults, children, and adolescents, including mobile, telephonic, diversion, respite, and walk-in services. Because mobile crisis services have been shown to be particularly effective for children, we support continued coverage of mobile crisis as a Medicaid-covered service.

Statewide Services Flexible to Meet Local Needs

As a best practice, we support providing urgent and emergent access to crisis services statewide. In providing the services, we place high value on local partnerships, such as the Alcohol, Drug Addiction, and Mental Health Boards, who will play a critical role in creating the suite of emergency services best suited to specific demographic and geographic needs. We have a flexible model and are adept at working with local entities to address the needs of their communities.

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?

AmeriHealth Caritas supports developing behavioral health performance measures that focus on functional outcomes. We recommend that ODM build on existing measures that use administrative data, including timely access to follow-up care after hospitalization or ED visits. Building on existing administrative measures and existing data-collection structures utilized by the providers themselves ultimately serves well to minimize provider burden while supporting reliable data collection. Other measures require EHR data collection and not all Ohio behavioral health providers are currently using EHRs.

Where relevant and applicable within select provider types and operating structures, AmeriHealth Caritas also recommends that ODM convene stakeholders to establish an aligned set of behavioral health performance measures, acknowledging that measures will have to be customized to fit the needs of providers and the populations of members they serve and focus on meaningful outcome goals from a population health perspective.

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.

AmeriHealth Caritas supports the use of American Society of Addiction Medicine (ASAM) criteria to evaluate the appropriateness of level of care and interventions for members with a substance use disorder (SUD). ASAM criteria facilitates increased access to services at the appropriate level of care by allowing providers to make clinical recommendations to increase the frequency of services at lower levels of care. We recommend that the MCOs collaborate with provider stakeholders to reinforce the consistent application of ASAM criteria.

Based on our experience, we also recommend use of utilization management tools such as notification or retrospective review for certain services, rather than prior authorization, to prevent utilization management from interfering with the member getting timely access to the full continuum of services.

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?

AmeriHealth Caritas has experience expanding provider capacity for care, including medication-assisted treatment (MAT) services and peer support services. We welcome the opportunity to work with the State to explore options to expand capacity including for telemedicine and peer support services. In our experience, the efforts should focus on three aims:

- Encouraging new providers (especially small or rural providers) to apply for Substance Abuse and Mental Health Services Administration (SAMHSA) Practitioner Waivers.

- Encouraging providers who have Waivers to treat up to the maximum number of patients allowed by their Waiver (e.g. treating up to 100 patients).
- Encouraging providers who have Waivers to treat up to 100 patients to apply for a Patient Limit Increase to treat up to 275 patients.

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?

AmeriHealth Caritas recommends that ODM consider the following strategies to support, shape, and improve provider performance and improve outcomes for members with SUD and opioid use disorder:

- Utilization of provider incentives, including value-based payments.
- Provider training, including on ASAM criteria, screening tools, and the principles of Substance Use in Adults and Adolescents: Screening, Brief Intervention and Referral to Treatment (SBIRT) protocols.
- No prior authorization for MAT medications by the PBM.
- Monitoring of opioid prescribers by the PBM with reporting to the MCOs.
- Expanded use of technology-informed bed management platforms to reduce waitlist time for inpatient stays.
- Inclusion of SUD crisis intervention services to support 24/7 screenings and referrals.
- Application of quality metrics that support recovery.
- Collaboration with strong community partners such as CCEs.

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?

AmeriHealth Caritas supports ODM in recognizing Institutions for Mental Disease as an In Lieu of Service (ILOS). Because ILOS can be challenging for both state agencies and MCOs to administer and offer limited benefit to members, we recommend that instead of expanding ILOS, ODM gives MCOs flexibility to use value-added benefits that support the member's journey to optimal health.

Supporting Providers in Better Patient Care
Questions 17 Through 19

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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.

AmeriHealth Caritas fully supports the Ohio Department of Medicaid's (ODM's) intention to implement a centralized credentialing process, and we look forward to the opportunity to collaborate with the State on solutions to common barriers. Our experience working with states as they move toward a centralized Credentialing Verification Organization (CVO) includes Medicaid markets like Louisiana and North Carolina. To help ensure quality and alignment with industry standards, we recommend the use of a National Committee for Quality Assurance-certified CVO.

Provider abrasion and dissatisfaction is a potential barrier to the successful transition to a centralized CVO as providers become accustomed to the new process. This dissatisfaction can unintentionally be compounded if the process is not implemented broadly enough. To minimize provider burden and abrasion, we ask ODM to consider using this transition as an opportunity to streamline the process and centralize the collection of information to populate provider directories, including provider specialty designation(s). This will help resolve an ongoing and significant data quality issue in Ohio related to inaccurate and out-of-date provider directories and inconsistencies among Managed Care Organizations (MCOs) regarding reporting of provider specialty designations. We suggest that the information that ODM collects act as the *source of truth* regarding provider data on specialty, office accessibility, and contact information.

To further promote an efficient and consistent process, additional solutions should incorporate:

- MCO and provider input on forms, process, and the role of the State CVO.
- Clear communication of the CVO role and expectations of all impacted parties.
- State-sponsored educational forums for providers, to establish and monitor expectations regarding turnaround times and data exchange.
- Credentialing at the provider level instead of the location level.
- Allowing sufficient time to capture relevant provider data to facilitate the collection of complete, accurate, and thorough information.
- Ongoing monitoring and reporting by the CVO.
- The CVO providing updates regarding the status of verification and transparency into the process.
- An ongoing customer feedback process that includes stakeholder forums and surveys.
- Recurring evaluation of the process that includes tracking and trending of complaints.

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.

AmeriHealth Caritas has experience in markets where there is a large percentage of delegated credentialing contracts, as well as in those with fewer delegated credentialing contracts. Whether a provider chooses to undertake delegated credentialing is largely dependent upon their willingness and capacity — factors which vary from market to market. We are happy to provide the number/percentage and types of providers in our Medicaid networks that have delegated credentialing status in a follow-up interview.

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.

AmeriHealth Caritas supports ODM's addition of the requirements listed in Question 18. We have experience with the same (or similar) requirements in other Medicaid markets and feel that these standardized administrative processes have the potential to streamline provider administrative processes and facilitate consistent delivery of high-quality care. We have detailed additional considerations of these requirements below.

We collaborate with state agencies and MCOs in other markets where we use only state-developed, standardized prior authorization and concurrent review forms and processes to reduce the administrative burden on providers. We welcome the opportunity to share these experiences in a follow-up interview with ODM. When implementing this requirement, we urge ODM to develop and use forms that are comprehensive enough to collect all of the information needed to make a proper determination. Inadequate forms can increase provider burden if MCOs are forced to request the provider supplement the information already provided.

AmeriHealth Caritas does not oppose MCO use of state-developed medical necessity guidelines, where they exist. However, MCOs should be permitted to develop their own policies based on industry standards for any services currently not covered by an existing ODM guideline. Allowing MCOs to administer their

own policies in these areas will eliminate unnecessary barriers to service approvals. MCO policies should be published for all stakeholders via a public page on the MCO's website.

State prior review and acceptance of MCO policies is a standard requirement in most of AmeriHealth Caritas' Medicaid markets. We urge ODM to allow for reasonable timelines to implement any requested changes to policies related to state-developed medical necessity guidelines and any other policies, as applicable.

Similarly, prohibition of MCO application of prior authorization for certain services is also a standard requirement in many Medicaid markets. However, our experience has shown that there is a risk of overutilization if prior authorization is not used for certain services. To prevent this, MCOs should be able to provide feedback regarding which services should or should not require prior authorization.

Most importantly, we encourage ODM to implement a collaborative process and seek MCO and provider input when developing standardized requirements. Through this process, MCOs and providers can weigh in on specific requirements and identify potential unintended consequences so that ODM can modify as needed prior to implementation. This allows for consideration of the perspectives of providers with different capabilities, panel sizes, and panel acuity levels who may have diverse needs.

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

We support ODM's plans to establish appointment availability standards. However, we urge ODM to also recognize that a narrow focus on the availability of specific providers and office-based appointments does not capture the full range of access options that health plans offer (e.g., telehealth visits, patient portals, and urgent care clinics). Best practices for monitoring appointment availability include the following approaches:

- Implementing centralized sampling for appointment availability surveys via a single external entity, so that providers who contract with multiple health plans are not surveyed multiple times.
- Surveying office locations (rather than specific providers) regarding appointment availability, in combination with centralized sampling or as a standalone strategy. The survey question would ask about the next available appointment at that office location, rather than with a specific provider.
- Investing time and resources improving the quality of provider contact data to avoid wasting resources sampling invalid contacts.
- Supporting and educating providers to increase their capability and capacity to meet appointment availability standards, thereby reducing the need for follow-up surveys/audits or corrective action.

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

As stated above, we highly recommend a state-driven, collaborative approach that brings MCOs and providers together to drive efforts to increase administrative standardization, reduce provider burden, and support greater consistency across MCOs. Cross MCO collaboration provides the opportunity to align performance measures and clinical practice guidelines across MCOs, where appropriate and practical. AmeriHealth Caritas has experience implementing these strategies collectively with MCOs in other markets and welcomes the opportunity to share this experience with ODM in a follow-up interview.

We recommend that MCOs collectively host recurring provider focus groups to seek input regarding sources of provider burden, opportunities for greater consistency, and possible solutions.

Most importantly, MCOs must truly listen to this input, be flexible in their approach, and use it as guidance to inform program design and processes. For example, through soliciting provider input in other Medicaid markets, we learned that one source of provider burden is missed appointments by members. Through

listening to this input, we have modified our process to work with providers to implement open scheduling approaches, where they set aside time or times to accommodate walk-ins.

These groups can also serve as a venue for MCOs to collectively educate providers regarding program benefits and limitations. Provider burden can sometimes be attributed to a lack of understanding about specific MCO processes and offerings. As such, MCOs must individually offer timely, relevant, and convenient provider training to confirm they understand the shared managed care processes and have the ability to leverage innovations, tools, and technologies offered by MCOs to reduce burden (e.g., streamlined claims processing and data exchange capabilities). Provider training and engagement should be tailored to the provider's needs and incorporate recurring and proactive in-person outreach and support.

Further, as detailed in our response to Question 21, using a statewide health information exchange (HIE) is optimal, although interconnected regional exchanges are an option. A federated model is also recommended, using HL7 with the Consolidated Clinical Document Architecture as the core standard. We have worked with multiple HIEs and found that stakeholders are more likely to be successful when the existing standards are used; unfortunately, we have also seen the opposite. In one state, the lead stakeholder required a non-standard use of the Continuity of Care Document with additional fields. While well-intended, the design and implementation took an extended period, had considerable costs, and resulted in low levels of adoption and impact.

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.

One of the biggest challenges we face in helping our members is a shortage of qualified medical professionals. This is a growing concern and presents a serious challenge to our mission to help people get care, stay well, and build healthy communities. AmeriHealth Caritas supports the State's efforts to develop and maintain a high-quality, multidisciplinary health care workforce. We have collaborated with the State, other payers, and providers across several of our markets to develop and implement numerous initiatives to attract and retain new providers, support existing providers in underserved communities, and expand the reach of providers using health care extenders. We would welcome the opportunity to participate in such efforts in Ohio.

We have found that incentives to expand the workforce must be substantial and relevant enough to attract and retain a diverse and interdisciplinary care team. Loan repayment, grant and residency programs, and community-based graduate medical education and fellowship programs are all key strategies. MCOs can work with Ohio's medical and dental programs to sponsor fellowships and provide educational opportunities for students to train in underserved areas and work with diverse populations, including low-income residents and individuals with disabilities.

Another way to address workforce development is through supporting providers as they expand their capabilities, capacity, and comfort level to provide additional services. This can include supporting opportunities for existing providers to gain knowledge and expand their skill set and team-based approaches to care that offer specialized support that enables the provider to offer additional services (such as behavioral health services within the primary care setting). Additionally, MCOs can help providers

identify opportunities to more effectively leverage physician extenders, community health workers, and peer supports specialists to deliver added services (as appropriate for their licenses) and assist members in addressing social determinants of health and potential barriers to needed care.

Creating Greater Confidence in the System Through Transparency and Accountability Questions 20 Through 21

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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.

Reducing Referrals for Fraud, Waste, and Abuse

AmeriHealth Caritas supports the Ohio Department of Medicaid's (ODM's) program goals of optimizing program integrity efforts that create confidence in the overall health delivery system through transparency and accountability. Our approach features a continuum of activities that start with automated system controls, comprehensive data management and analytics, and pre-payment review activities. Additionally, we support post-payment review, and activities such as contract management, subcontractor monitoring, education and outreach to members and providers, and staff and subcontractor training. Applying our comprehensive approach will help reduce fraud, waste, and abuse referrals to ODM or other State entities, such as the Ohio Attorney General's office. All managed care organizations (MCOs) should place a strong emphasis on prevention and pre-payment cost avoidance efforts, as they are more fiscally effective than pay and chase/recovery activities.

We understand that ODM, MCOs, and other key stakeholders meet regularly to discuss program integrity issues, share information and best practices, discuss emerging fraud schemes, and collaborate to resolve concerns, and reduce referrals. We look forward to actively and collaboratively participating in this process to continually enhance program integrity and safeguard State dollars, while making sure members have adequate access to medically necessary care.

Types of Prepayment Review Activities

There are three general types of pre-payment review activities MCOs conduct:

Edits for Common Coding Issues — This activity is generally automated as part of the claim adjudication process. Each claim is checked for member eligibility, provider eligibility, service coverage, correct coding, and medical necessity. MCOs should edit against ODM coverage standards for duplicate services and maximum allowed visits. Coding edits check the claim against Centers for Medicare & Medicaid Services (CMS), American Medical Association (AMA), National Correct Coding Initiative (NCCI), and other commonly accepted guidelines for correct coding and claim submission. These edits should be mutually agreed upon by all parties. MCOs also should implement clinical edits to review for medical necessity and quality of care for members. While many of these edits can be standardized, MCOs should have the flexibility to establish other edits based on medical necessity. Examples of coding edits include:

- Cost avoidance: For physical health/behavioral health claims, MCOs should use ODM-approved standard, systematic edits to cost avoid claims including:
    - Duplicate services.
    - Maximum allowed visits.
    - Gender and age restrictions/appropriateness.
    - Covered services.
    - Member and provider eligibility.
    - High-cost or other outlier services (e.g., holding/pausing claims for review before adjudicating claims, for additional review over a certain dollar threshold, or unusual utilization patterns).

- Pharmacy Point of Sale (POS) edits (if pharmacy claims continue to be carved into managed care): POS edits (such as screening for therapeutic duplication, overuse, drug interactions, exceeding limits, and refilling too soon) should promote cost avoidance over pay and chase.
- Clinical edits: While many edits can and should be standardized across plans, MCOs should have the flexibility to establish other edits based on medical necessity.
- Customized edits: Enable MCOs to develop and implement customized edits in response to claims data analytics or identification of new fraud schemes to foster cost avoidance and stop new schemes up front versus pay and chase.

Internal Review Process — This type of activity allows MCOs to use internally developed criteria and customize decision points in determining the appropriateness of claims and payments. MCOs analyze trends among provider types and services to build customized edits. Additionally, this internal review allows MCOs to analyze utilization data and use medical director insight to initiate new edits that avoid inappropriate payments.

Pause Process — Through this activity, high-dollar and outlier claims are pended for further review. Often, these claims are reviewed by certified coders and medical directors, and may require submission of additional information such as itemized bills or medical records to validate that the claim is appropriate.

Engaging Medicaid Managed Care Stakeholders in Standardizing Prepayment Edits

In other markets, AmeriHealth Caritas continually engages the state, internal experts, and specialized vendors to analyze claims data and look for ways to improve, enhance, and standardize claims edits where feasible to meet managed care goals. Standardized pre-payment edits should be mutually agreed upon by all parties and be based on CMS, AMA, NCCI, or other commonly accepted guidelines. Standardizing edits should support managed care principles such as appropriate utilization and promoting member access to medically necessary covered services while reducing provider burden.

While standardized edits can help reduce provider administrative burden by streamlining their claims submission process, allowing individual MCOs to customize pre-payment edits that support managed care goals and improved health outcomes is necessary to optimize MCO flexibility to respond to specific population and provider utilization patterns. We strongly recommend maintaining MCO ability to turn edits on or off, including prior authorization edits, to enable control of inappropriate utilization and payment. Offering providers a common portal where they can find standardized and customized edits (by MCOs) would give providers a centralized location to help them understand the differences and mitigate administrative burden.

Developing MCO-Specific Edits Based on Analytics

MCOs should be able to implement customized edits to address issues and trends specific to their enrolled membership and provider network. Ongoing MCO analysis of utilization and other data and medical director insight can identify issues and trends that indicate potential fraud or inappropriate utilization, such as an increase in members seeking opioid prescriptions from a particular doctor or group. MCOs should have the flexibility to develop edits to address these issues and trends to support appropriate payment.

Quantifying and Demonstrating Pre-payment Cost Avoidance Activities

We recommend that ODM require MCOs to capture and report on all program integrity data activities, including pre-payment and cost avoidance activities. This should include:

- Number of activities completed through each type of pre-payment review process.
- Number of claims by provider type that go through a pre-payment review process.
- Number of claims pended (total and by category of what was reviewed).

- Total estimated amount of savings or cost avoidance achieved overall and by each type of pre-payment review process.

Other examples of metrics MCOs should report are provided below in Question 20b. ODM can verify these activities and total cost avoidance by requiring MCOs to submit denied claims as encounters to the State.

Additionally, MCOs should submit reports to the Special Investigations Unit (SIU) of claims that may constitute fraud, waste, or abuse. MCOs should work collaboratively with SIU and provide full access to overpayments and pre-adjudication pend and denied claims. ODM can also use MCO reports and SIU submission of cases to ODM to evaluate effectiveness of pre-payment review activity.

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?

ODM should require MCOs to provide reports with metrics that reflect both prospective and retrospective savings to gain insight into both programs. We recommend that ODM consider requiring all MCOs to consistently report the following types of metrics:

- **Percentage of total claims by provider type** with cost avoided due to cost avoidance edits, such as:
    - Third party liability/other health insurance to help ensure Medicaid is the payer of last resort.
    - Claim filing limits.
    - Benefit limitations/maximum allowed amounts/prior authorization.
    - Billing for drugs, equipment, or services that are not medically appropriate (such as age, gender, appropriate provider type, etc.).
    - Duplicate services.
    - Member and provider eligibility.
    - Coding mismatches.
- **Percentage of claims by provider type** with cost avoided for suspended claims for pre-payment review based on criteria such as:
    - Claims exceeding a specified high dollar threshold.
    - Anomalous billing and aberrant utilization or prescribing patterns.
    - Provider already on payment hold or pre-payment review due to program integrity/surveillance utilization and review investigation.
    - Unbundling of services.
    - Prescribing high quantities of controlled substances without medical necessity.
- Number and types of cases **by provider type** reviewed and resolved by an MCO internal program integrity unit without referral to the Medicaid Fraud Unit; number of claims audited and dollars adjusted due to program integrity post-payment review.
- Number and type of cases **by provider type** referred to the Medicaid Fraud Unit**,** including date referred, response status, days pending, dollars recovered, and trends over time.
- Education and training of members and providers related to preventing fraud, waste, and abuse. This should include a variety of methods (online, individual, published material, and group). Topics should include trends over time that show a reduction in recurrence of common billing practices that could be potentially fraudulent.

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.

Adjusting program integrity approaches for value-based payment (VBP) models is new to the Medicaid delivery system and has just begun to be discussed by CMS, states, and MCOs. AmeriHealth Caritas recommends that ODM develop a program integrity framework specific to VBP models in alignment with program integrity guidance developed by CMS and guidelines from the Health Care Payment Learning & Action Network for how to operationalize program integrity approaches within this new type of payment model. This framework should be developed in collaboration with each contracted MCO and provider participants from across the State, leveraging any existing program integrity workgroup(s). AmeriHealth Caritas recommends that the framework include collaboratively developed program integrity metrics and benchmarks that MCOs must include in VBP alternative payment model agreements. We also suggest that the framework connect provider payment incentives to program integrity performance scores. A program-integrity-based incentive program will help achieve ODM's program goals, cost containment targets, and transparency initiatives, while minimizing provider abrasion.

Our VBP programs prioritize regular performance monitoring, data sharing, collaboration, and provider education. Each of these components can address program integrity concerns related to quality, withholding care, and provider abrasion. Additionally, all of our VBP models are governed by quality. Providers must meet minimum quality thresholds to be eligible for incentive payments. Prioritizing quality performance in VBP program design mitigates risks related to withholding care and underutilization. We recommend monthly monitoring of providers participating in VBP programs to quickly identify outlier performance or sudden shifts in performance. For example, a sudden drop in medical loss ratio may indicate underutilization or other quality issues. Early identification of these issues gives us the opportunity to address concerns with the provider so that they can make the required adjustments.

We recommend use of metrics that prioritize the delivery of quality care to members over cost. There are many metrics that may be used (such as minimum medical loss ratio requirements, target encounter rates, etc.) and each or several may be applied to effectively monitor program integrity, depending upon the type of VBP model being implemented (e.g., shared savings, full-risk, episode-based payments, total cost of care, or prospective population health payments). However, all metrics must be based on quality and value. Providers should be required to meet minimum quality benchmarks (like HEDIS® access to care measures) defined during program design to qualify for incentive payments.

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).

AmeriHealth Caritas recognizes the critical importance of timely, secure, and efficient clinical data sharing across all entities involved in coordinating and managing an individual's care. This will be even more important if the State incorporates Care Coordinating Entities (CCEs) into the Medicaid managed care model and expands the number of entities that need member data.

CCEs and MCOs will need to share meaningful data and information with each other. Depending on CCE scope of responsibility, types of care management data and information the CCE may need from the MCO include:

- Member demographic information.

- Physical and behavioral health diagnoses and status.
- Functional needs and status.
- Screening and assessment results.
- Care plans.
- Care team information.
- Utilization history, including hospitalizations, ED use, and pharmacy.
- Laboratory values.
- Risk scores.
- Care gaps.
- Advance directives.
- Caregiver information and needs.
- Individuals authorized to participate in care.
- SDOH information.

We recognize that ODM intends to carve pharmacy and some behavioral health services out of the benefit package covered by MCOs. MCOs will still need timely, accurate data on these services to appropriately and effectively manage member care. Depending on CCE scope of responsibility, CCEs may also need this data. Types of data and information generated by the CCE that the MCO may need include:

- Updates to member demographic information.
- Screening and assessment results.
- Monitoring information.
- Care or service plans.
- Monitoring information such as potential changes in condition.
- Updates to caregiver information.

Our experience in other markets has highlighted some best practices in the successful exchange of data and information. From the MCO standpoint, the ability to share data depends upon the other parties' ability to receive data. We make data available through multiple avenues, giving recipients options that align with their varied capabilities to receive data. Another important consideration for large-scale data exchange among multiple entities is to develop and agree on shared file formats and content. This includes formats for key documents that may need to be exchanged, such as care plans. Setting up a standard format reduces the need for each entity to translate from one format to another. We recommend that ODM align to a standard when one already exists. If no standard exists, we recommend the State facilitate MCOs and stakeholders (including CCE and health information exchange (HIE) representatives and providers) collaborate to generate one. Planning collaboratively for data exchange across an expanded number of partners in health care will facilitate continuity across MCOs and between stakeholders involved in care coordination and management.

We recommend that ODM build sufficient time into the pre-implementation period to allow for adequate testing to determine that data sharing is working as intended. We currently participate in collaborative efforts to plan for data exchange across the State, MCOs, external care coordination entities, and providers in both Pennsylvania and North Carolina, and welcome the opportunity to share more details and lessons learned with ODM during an interview.

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).

In our experience, the best practice for providing ODM with real-time access to data systems (virtual access or by having ODM staff onsite) is determined by the objectives for the access:

- Virtual and remote access is a best practice for providing operational and/or summary reporting data to key stakeholders. This includes real-time ODM access (utilizing two-factor authentication) to information on configurable portals and mobile devices.
- Having ODM staff onsite is a best practice for highly-collaborative and/or oversight functions. Examples include an MCO working together with ODM to resolve member-specific issues or providing ODM staff the ability to listen to live member calls for performance monitoring.
- Real-time access is the best practice for transactional data. In the event this type of data is needed, MCOs should use industry-standard HIPAA 5010 ASC X12N real-time transaction types. This would include 270/271 Health Care Eligibility and Benefit Inquiry and Response; 276/277 Health Care Claim Status Request and Response; and 278 Services Review Request for Review/Response.
- Where needed, MCOs can develop custom Application Programming Interfaces (APIs) to provide states with access to data which may not be otherwise accessible via standard real-time electronic data interchange standard transactions, such as changes of address and dates of death.

Due to the large number of disparate systems that will be used by multiple MCOs to provide care to Ohio Medicaid members, understanding the specific data necessary to meet the State's needs will determine the most efficient, secure method for providing ODM with real-time access to data.

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.

Using Ohio Health Information Exchanges and Other Real-Time Data

AmeriHealth Caritas is a recognized thought leader in data interoperability and data exchange. We regularly share our expertise with providers and health plans at cross-industry conferences, such as Health Information and Management Systems Society and America's Health Insurance Plans.

We believe multi-stakeholder State/regional HIEs provide the best interoperable infrastructure for sharing real-time data. These organizations act as community health assets that serve all entities, are Electronic Health Record (EHR) vendor agnostic, and address salient use cases that improve health outcomes. The standardized hub-and-spoke HIE model simplifies both decision-making (allowing for more rapid innovation) and technical implementation (creating a lower barrier to entry).

MCOs should integrate data received from HIEs into their care management platforms and processes for a variety of purposes, such as to stratify their populations, identify risks and the need for intervention, monitor and evaluate care, and allow providers access to timely, actionable information to inform care delivery. The interoperable infrastructure should support a wide range of exchange methods including Admission, Discharge, and Transfer (ADT), Continuity of Care Document (CCD), and Direct Secure Messaging (DSM), which facilitates point-to-point sharing of patient data between providers. DSM has a relatively low barrier-to-entry for providers while providing greater portability of medical records in a secure fashion. Other methods to consider include Cross-Enterprise Document Sharing and the Fast Healthcare Interoperability Resources® (FHIR) standard.

Data Elements and Formats AmeriHealth Caritas Shares

Data elements should follow industry standards in order to establish a common understanding of data across all stakeholders. HIE trading partners should avoid the exchange of internally developed ("home-grown") coding standards. Our data exchange platforms are based on health care industry interoperability standards, including:

- **Health Level Seven (HL7)** — ADT, CCD, DSM, and FHIR transactions.
- **HIPAA ASC X12N transactions** — 820 Payroll Deducted and Other Premium Payment; 834 Benefit Enrollment and Maintenance; 835 Health Care Claim Payment/Advice; 837-I Health Care Claim: Institutional; 837-P Health Care Claim: Professional; 837-D Health Care Claim: Dental; 277CA Health Care Claim Acknowledgement; NCPDP; Direct Deposit Claim Payments.
- **Standard code sets** — ICD-10; HCPCS; CPT-4; National Drug Code; Logical Observation Identifier Names and Codes; Home Infusion Electronic Data Interchange Coalition Product Codes; American Dental Association Current Dental Terminology; Diagnosis-related Group; Claim Adjustment Reason Codes; Remittance Remarks Codes.
- **HIPAA 5010 ASC X12N real-time transaction types** — 270/271 Health Care Eligibility and Benefit Inquiry and Response; 276/277 Health Care Claim Status Request and Response; 278 Services Review Request for Review/Response.
- **Other real-time transaction types** — Custom data transaction types created for specific purposes where an industry standard does not exist, including member ID card information, care team contact information, panel rosters, member care gap information, and member clinical summary.
- **Future data types** — Our flexible, service-oriented architecture allows us to build and integrate new sources of data, including but not limited to, external socio-economic data sets, social determinants of health information (SDOH) for our members and their communities, and personal biometric data from remote devices.

Extent of Current HIE Utilization by AmeriHealth Caritas and Network of Providers

AmeriHealth Caritas maintains relationships with eight state/regional HIEs in Michigan, Pennsylvania, Florida, Louisiana, Delaware, and the District of Columbia. AmeriHealth Caritas health plans exchange more than 175,000 ADT and CCD transactions monthly. Data received from HIEs is tightly integrated into our care management platform and processes. For example, we have developed a sophisticated multi-state HIE gateway that is integrated with our care management platform and our provider portal. This allows our care coordinators and providers to be alerted to discharges and changes in status that require intervention in as close to real time as possible.

How to Work With Other MCOs to Standardize Approach to Data-sharing

To promote interoperability across MCOs, providers, and CCEs, we recommend using industry-standard formats (such as HL7, EDI HIPAA 5010 ASC X12N transaction sets, and FHIR) and avoiding the use of propriety formats, wherever possible. Where standards already exist, these should be considered for adoption. Where they do not exist, we recommend a collaborative process led by ODM and including MCOs, providers, CCEs, and other stakeholders to develop these standards. We support the vision of the Trusted Exchange Framework and Common Agreement to accelerate interoperability across the health care delivery system. We encourage ODM to use the Office of the National Coordinator's (ONC) pending rule on the proposed Trusted Exchange Framework as part of standardizing 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.

MCOs manage and expand upon Business Intelligence tools and advanced analytics platforms that transform information and derive insights from a wide variety of internal and external data sources. As a best practice, MCO systems should have the capability to incorporate and process this vast amount of data to support holistic coordination and management of health care services, and provide for a comprehensive, longitudinal view of each member's unique needs. Member data required to accomplish this includes, but is not limited to, claims and utilization data for physical health, behavioral health, pharmacy, laboratory, dental, vision, and other SDOH, which may come from internal operational and clinical systems, contracted vendors' systems, health systems' EMR/EHR data, and/or data from non-traditional health providers and community organizations.

We understand that powerful insights are directly tied to the validity and veracity of our data, and so, from a contracted vendor perspective, the link between timely and accurate data and contracted vendor oversight is paramount. Therefore, we strongly recommend close oversight of delegated vendors providing contracted services, including but not limited to progressive sanctions for noncompliance, up to and including financial penalties and contract termination. If data quality, non-submission of records, or other issues are identified, they should immediately be reviewed with the contracted vendor. If deficiencies are not corrected in a timely manner, contracted vendors should be required to provide corrective action plans documenting the root cause, remediation activities, and remediation dates. Contracted vendors who continue to miss performance standards should be subject to financial penalties and/or termination.

Successful MCO integration of internal systems and incorporation of data from contracted vendor (e.g., pharmacy, laboratory, behavioral health, and SDOH) is critical for delivering effective population health management for communities and personalized, holistic care for members.

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

Major considerations impacting MCO plans to apply real-time eligibility updates include:

- The ability of all stakeholders in the process to deploy real-time eligibility capabilities. Though most State entities and contracted vendors have increased the frequency of eligibility updates from monthly to daily, these updates are typically accomplished via point-to-point batch interfaces versus real-time APIs. Our core administration platform is capable of applying both batch and real-time eligibility updates.
- The inherent complexities of the Medicaid eligibility process similarly impact the ability and feasibility to apply real-time automated eligibility updates. These include, but are not limited to, retroactivity, newborns, and changes in program status.

While the aforementioned real-time eligibility update considerations are being addressed, we have been successful in exchanging member alert information with states on a real-time basis triggered by changes to specific data elements, including changes of address and dates of death. These types of transactions could be pursued as a potential pilot and/or *quick win* in Ohio.

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.

As the organization responsible for coordination of member care, the MCO is typically the stakeholder with the most interaction with the member. As such, the MCO is well-positioned to improve the accuracy and timeliness of an individual's eligibility and demographic information. We have made significant

investments in member engagement over the years and would recommend that ODM work with us to take advantage of those investments.

AmeriHealth Caritas finds that accuracy and timeliness of eligibility and demographic information is most effectively improved when the MCO can be a source of revised information. This includes:

- Providing ODM with updated member information based on MCO interactions with the member.
- Permitting the MCO to use updated member information (e.g., known current phone number) without waiting for the transmission of the updated information to ODM and back to the MCO in an 834 Benefit Enrollment and Maintenance file.

We also recommend that ODM provide the member's redetermination date on the eligibility file. This will allow MCOs to identify members with upcoming redeterminations, provide them support for the redetermination process, and help prevent eligibility churn. We have had a high degree of success in deploying multi-channel redetermination campaigns that have resulted in members taking the appropriate action to avoid lapses in their eligibility status. We welcome the opportunity to share our specific experience, approaches, and outcomes in an interview with ODM.

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

As a fully integrated health plan, we have access to comprehensive data that can be used to inform our population health strategy. This includes, but is not limited to, pharmacy and behavioral health data. As noted previously, if these or other services are carved out of managed care, it is important to establish an effective mechanism for sharing real-time data using a standard format across all vendors, MCOs, and CCEs. Additional data that could be shared to inform MCO population strategy includes but is not limited to:

- Member self-reported data such as results from previous health risk assessments SDOH screenings, and race, ethnicity, and language information.
- Community-level data (e.g., 211 data, transportation patterns, and locations of grocery stores and schools).
- Information from state databases, such as immunization registries, public lead poisoning and other health surveillance data, vital statistics from the Department of Health, and medical data on members who received treatment from the Department of Rehabilitation and Correction.

General Feedback
Questions 22 Through 23

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General Feedback

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?

Procurement Design and Process

In our experience, managed care program redesigns and rebids are an opportunity for state policymakers to challenge both current and prospective health plans to offer new solutions and best practices, innovate, and advance the overall quality of the program. To harness the benefits of competition in the interests of advancing the Ohio Department of Medicaid's (ODM's) goals, careful consideration should be given to the design of the procurement itself so that the structure, process, and requirements do not disadvantage potential new entrants. An even playing field for both incumbents and non-incumbents is necessary to spur incumbents to raise the bar over current operations and encourage non-incumbents to bid. For example, we recommend that the State allow bidders to provide a detailed strategy for developing a strong provider network prior to go-live to measure provider network adequacy rather than requiring signed contracts.

Because ODM is considering a number of significant program changes, it will be critical that all stakeholders and potential bidders fully understand the new program goals, structure, and requirements. It is equally critical that ODM identify and avoid unintended consequences. To that end, AmeriHealth Caritas recommends the following:

- **Release a Draft Request for Applications (RFA).** Releasing a draft RFA gives ODM the opportunity to ask for additional feedback from stakeholders before the release of the final RFA. Benefits of this include receiving more targeted feedback on the final proposed program, better insight into potential stakeholder concerns and questions ahead of the formal procurement process, and the opportunity to edit and improve the final RFA and procurement approach before RFA release. This can lead to a smoother procurement process and better, more informed applications that fully address the needs and priorities of the state of Ohio.
- **Hold a Mandatory Bidders Conference after Releasing the Request for Applications.** Holding a mandatory conference for potential bidders early in the formal procurement process lets ODM know what organizations are likely to submit an application. It is also an early opportunity to address questions and provide clarity to these potential bidders. Even if answers cannot be provided to all inquiries at the conference, ODM will benefit from insight into the types of questions they will receive through the formal question and answer process.
- **Offer at Least Two Question and Answer Periods Between Final RFA Release and Application Due Date**. We strongly encourage the State to allow for at least two question and answer periods during the procurement process to allow for clear bidder understanding of all requirements and ODM answers. Additionally, we encourage that all State answers be provided in a timeframe that allows bidders to adequately consider impact of answers on operations and approach, incorporate the information in their planning, and reflect it in their applications.

Adequate Time and Collaborative Approach to Facilitate Smooth Implementation

An adequate lead time and a highly collaborative approach to plan and prepare for program implementation will also be key to achieving program success. ODM envisions major changes to the current program, which introduces opportunity as well as risk. We recommend careful consideration of how much lead time is needed to help ensure all managed care organizations (MCOs), providers, Care

Coordinating Entities (CCEs), and other stakeholders are ready for go-live. This will include time to identify potential issues and make course corrections prior to implementation. For example, given the multiple new entities with which MCOs may be required to exchange data, sufficient time for system testing is critical. Any changes to geographic regions as well as regional awards may impact provider contracting timeframes. Outreach and education for providers, members, advocates, and other stakeholders will need to be more intensive than usual, given the extent of planned program changes.

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.

With over 35 years of experience serving Medicaid populations, AmeriHealth Caritas understands the impact economic downturns have on our members and our state partners. The socioeconomic and health factors that our members face are often intensified during an economic downturn, and these factors play an important role in access to quality health care and the type of programs required to improve health status. Additionally, Medicaid eligibility tends to increase with economic downturns, bringing new members into managed care who may not be familiar with Medicaid. During an economic downturn, our innovative approach to serving members remains focused on the unique needs of each individual — from their physical health to the broader range of behavioral, social support, and long-term services, and other needs including health literacy and understanding of Medicaid benefits and how to access them appropriately.

With Medicaid now covering more adults, it is more important than ever for states to have a strategy in place to address the effects of an economic downturn on the Medicaid program and budget. The State could use the MCOs for the following activities:

- Work with the State's Dislocated Worker Unit to manage care transitions into Medicaid during plant closings or mass layoffs.
- Add an employment screening and assessment to the new member screening and assessment process already performed by the MCOs.
- Work with the State to share data and partner with state and local agencies on workforce linkage, training, and employment programs to help members develop skills and get additional training and other supports to position them for success when the economy begins to recover.
- Work with MCOs to target members for invitations and offer pop-up health clinics in partnership with hiring events to increase participation.
- Help smooth the transition out of the Medicaid program for members returning to work through linkages to other sources of coverage and with assistance transitioning care to new coverage and providers through transfer of data and records, and participation as requested by the new source of coverage or provider in case conferences.

Interview
Question 24

Delivering the Next
Generation
of Health Care

AmeriHealth Caritas™
Ohio

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.

Opportunity for Interview

AmeriHealth Caritas respectfully requests the opportunity for an interview with the Ohio Department of Medicaid to discuss our response to the Ohio Medicaid Managed Care Program Request for Information #2 regarding Ohio Medicaid's future managed care program. We look forward to discussing your vision for advancing Medicaid managed care in Ohio, how our capabilities could support your goals, and demonstrating how care is truly the heart of our work.

Requested Information	
Name of entity or organization	AmeriHealth Caritas Ohio
Entity Type	Managed Care Organization (MCO)
Point of contact, including name, telephone number, and email address, for the purpose of scheduling the interview	Peter A. Jakuc (267) 298-2490 pjakuc@amerihealthcaritas.com
Name, title, and employer of proposed attendees to the interview, including any contracted lobbyists or consultants	Peter A. Jakuc Senior Vice President & Chief Development Officer AmeriHealth Caritas Tom Lyman Senior Vice President, Market Development AmeriHealth Caritas

Requested Information	
	Mary Pat Sherry Director, Market Development AmeriHealth Caritas Karen Michael Vice President, Population Health Programs AmeriHealth Caritas BethAnn Smetak Vice President, Service Operations AmeriHealth Caritas Scott Vasey Senior Vice President, Network Management AmeriHealth Caritas Jim Jones Vice President, Healthcare Analytics AmeriHealth Caritas Samantha Murphy Director, Behavioral Health Strategic Initiatives AmeriHealth Caritas
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	All questions and topics included in our response to Section V of the RFI, including: • Emphasizing a personalized care experience. • Managed care structure. • Improving wellness and health outcomes. • Improving care for children and adults with complex needs. • Supporting providers in better patient care. • Creating greater confidence in the system through transparency and accountability. • General feedback.