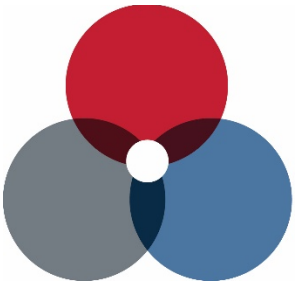

THE CENTER FOR COMMUNITY SOLUTIONS
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RESEARCH • ANALYSIS • ACTION

The Center for Community Solutions Response to

Ohio Department of Medicaid

Request for Information (RFI)

JULY 23, 2019

1501 Euclid Avenue, Suite 310

Cleveland, OH 44115

EXECUTIVE SUMMARY

The Center for Community Solutions believes that Ohio's Medicaid program is strongest when built on sound, cost-effective policies that maintain access and improve quality. Managed care organizations, as private companies, represent the state government's best effort in effectuating the policy ideas through a contract. To that end, Community Solutions would like to respond to the Request for Information issued by the Ohio Department of Medicaid in June, 2019 with a focus on two themes, social determinants and mandatory data sharing.

1. FOCUS ON SOCIAL DETERMINANTS AND EQUITY IN CONTRACT DESIGN

It is well known that non-clinical factors significantly impact health outcomes. While the state needs to consciously invest in resources outside of Medicaid to accomplish better efficiency in this area, Medicaid managed care can play a more significant role in acting as conduit between the human service and medical delivery systems. Specifically, managed care should take a more active role indexing and understanding social determinants as an insurance risk and be incented to address them beyond the current community-engagement requirements. The state should create specific contractual mechanisms, both in basic rate construction and risk-based arrangements. These mechanisms would consider social determinants as elements of insurance risk and create better legal mechanisms whereby the case management of these social determinants can be more easily exported to community agencies, allowing managed care to act as a platform for value.

Further, equity, as a policy notion, acts as code for systemic poverty and racism. While there are conscious design elements to many programs relative to race and economic conditions, the state should implement the framework offered by the National Quality Forum on equity inclusion measures which address the concerns of Ohio's rural residents, who disproportionately rely on managed care for their coverage.

2. GREATER PRACTICE AND PAYER INTEGRATION FOCUSED ON MANDATORY DATA SHARING

Money in the medical system does not go to beneficiaries. Rather, the system is financed by beneficiary taxes and allocated through the state, via managed care for services rendered by providers. The system of care, however, remains fragmented, especially as it comes to case management and the data associated with delivery.

Providers are often unaware of the non-clinical and utilization information they do not collect directly. Payers do not have access to clinical information until it appears as a claim. Simply, if those systems remain disconnected, there will be fragmentation. One way to address this is by allowing vertical integration of the two sectors though accountable care, though the effective design is paramount in terms of maintaining access and keeping the price of services reasonable. The other path involves the state creating market conditions under which providers, payers and community organizations are compelled to co-manage success through the adequate sharing of information without an accountable-care model. In some areas of the contract, this integration should be a condition of reimbursement and, in others, this should be incented through managed care risk arrangements tied to the medical loss ratio, market share, rates and payments that include withholdings and bonuses. Lastly, there should be some contemplation about having community-based organizations more involved in the continuity. This includes providers, such as those in the behavioral health system, but must also include agencies which address the housing, food, educational, vocational and legal needs of common populations.

OTHER RESOURCES

To provide more detail than what could be provided in the executive summary or responses, please see the following resources we have developed on various policy concepts:

Social Determinants
Housing
Education
Food
Transportation
ACEs

Managed Care
Engineering Outcomes
Data

Communication and Engagement with Individuals Enrolled in Managed Care Plans

Access to Care

1. As an individual enrolled in a managed care plan, how often do you have difficulty obtaining access to services?

- Less than one time a year
- Approximately once a year
- More frequently than once a year
- More frequently than one time a month

The Center for Community Solutions Has No Comment

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

Many enrollees in managed care do not enroll actively, meaning they are auto-enrolled or made eligible as a function of the financial reconciliation of providers (via retroactive and presumptive eligibility). Managed care organizations (MCOs) are limited in ensuring continuity of eligibility for their specific product in order to maintain standards around choice.

Additionally, the attribution of Primary Care Providers (PCPs) and MCO case managers to beneficiaries is poorly managed and not well communicated between providers and plans and beneficiaries. Despite the requirement for PCP assignment, PCPs do not often know if their patients are covered or if they have case managers. According to the state's most recent External Quality Review (EQR) MCOs Managed Care Provider Network (MCPN) survey results demonstrated a PCP address accuracy rate as low as 36.6 percent, an OB/GYN telephone number accuracy rate of 52.6 percent and a home health agency (HHA) telephone number accuracy rate of only 50.4 percent.[1]

As a condition of contracting with providers with a larger panel size as determined by the state, MCOs should be able to communicate attribution on a regular interval with providers as well as maintain a single source of information (call-in line or online database) to determine case manager attribution as well as facilitate the reassignment of a PCP where indicated by the patient. This should be a quality measure that the state ties into mutual risk between provider and MCO and set at a threshold greater than historical performance in attribution. For specific, high-risk populations, MCOs should make efforts to directly communicate with the PCP, synchronously, and ensure the PCPs know the assigned case manager and the potential needs, relevant utilization and risk-relevant information of the beneficiary. Upon the awarding of these contracts, the state could utilize LeanOhio and rework the process of attribution with key representatives from MCOs, the Ohio Hospital Association, the Ohio State Medical Association and other trade associations representing medical professions to identify the best ways to improve this metric.

[1] https://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/External-Quality-Review-Technical-Report-2018.pdf

Also, while Ohio does produce a "report card" on managed care, this does not adequately represent Ohio's performance relative to peers, nationally, as represented by other, more comprehensive, state reports. While this presents an opportunity for value-based design to adjust incentives to align with this process, more can be done to communicate an MCO's value to the consumer. The state should recalibrate how it evaluates performance, raising the standards of what is considered "poor," "average" and "high performing" in its value-based reporting per the recommendations outlined in the most recent EQR.

Communication

3. How often do you receive communications from your managed care plan regarding your health care needs?

- Less than one time a year
- Approximately once a year
- Monthly
- Never

The Center for Community Solutions has no comment

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

- Please provide any specific feedback for the following groups:
  - Individuals who primarily speak a non-English language
  - Individuals with cognitive or intellectual disabilities
  - Individuals with physical disabilities
  - Individuals who may not understand health care terminology

  The state could require MCOs to perform an assessment built off of the Agency for Healthcare Research and Quality health literacy tool for a representative sample of its members by eligibility category and/or demographic groups where appropriate.[2]

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

The beneficiary should be able to contact his or her case manager as needed. Any additional behavioral tools deployed by the plans via apps or mobile technology should not affect eligibility or benefits in any way that diminishes the federal standards of essential health benefit coverage. Information on utilization of the apps should never be sold to third parties.

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

During the initial risk assessment plans conduct, a question about availability of this sort of technology should be identified and provided to the state.

[2] https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html

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

MCOs are already required to form Family Advisory Councils which is helpful in overall engagement. With that said, broadening the council beyond the regional level may be worthwhile. This could be done by making requirements to have councils available on the county level or by collecting information at Job and Family Service Departments in most counties every calendar year. The state could also require councils in cities with high Medicaid enrollment.

The state should also consider a "secret shopper" program for each of the plans wherein customer service integrity, regarding the key functions of the plan, is tested and evaluated across populations and geographies.[3] This should also be focused to ensure network adequacy for Health Professional Shortage Areas (HPSAs).

Engagement

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

A risk assessment which includes a quantification of barriers to achieve certain healthy behaviors would be helpful if this information is provided to the principal primary care provider in charge of that individual's care. This should include, but is not limited to, indexing social determinants which interrupt an individual's ability to follow medical advice. What's more, for any documented unhealthy behaviors (e.g. smoking) the MCO should share that information with the provider and offer any resources available directly with the MCO. Similarly, providers should be encouraged to perform a similar screen not only for social determinants, but for the likelihood of exposure to trauma through the use of the Adverse Childhood Events (ACEs) or the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tools.

Provider search

7. How could managed care plans make it easier for individuals to search for providers? In particular:

- What tools and resources would be most helpful (e.g., calling member services, online provider directory, hard copy provider directory, mobile application)?

  A single, statewide number that is MCO agnostic and can help people answer any question regarding their coverage, benefits and provider availability. For higher-risk individuals, this should include a direct connection to their case managers, where indicated.

- Within those resources, what type of information should be provided to help an individual choose a provider?

  MCOs should consider the risk assessment and the patient's needs with this consultation. If, for example, the individual is diabetic, that patient should be connected to a PCP with training in this area. If they are an expectant mother, the provider should have experience in family medicine,

[3] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1554

delivery, obstetrics, etc. In all cases, the patient's preferences should be accommodated and the MCO should make every effort to ensure continuity between settings and provider types, keeping the PCP informed with any new information relative to case management.

• Are there ways to make these resources more accessible and easier to use?

Upon enrollment, MCOs should identify a PCP for their enrollees if one does not exist. Once indicated, the MCOs should contact those providers and provide information about the patient's medical history and social determinant needs as referenced in earlier responses. To assist, MCOs should have mandatory access to the Ohio's Health Information Exchange (HIE), CliniSync.

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

The Center for Community Solutions Has No Comment

Grievances and Appeals

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

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

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

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

Provider Support

Standardization across managed care plans
13. Provide suggestions about how ODM could promote greater consistency of prior authorization requirements across managed care plans (e.g., requiring all managed care plans to use the same state-developed prior authorization form, or having the state establish which services can/cannot be prior authorized), including the pros and cons, potential barriers, and ideas for addressing those barriers.
As a part of the hand-off to the PCP, the number for prior authorization review should be provided. Also, all historically honored PA requests should be grandfathered in unless otherwise medically indicated.

If the PA request is submitted for a high-risk beneficiary, as defined by the Department, the case manager should reach out to the PCP and discuss the request in a timely manner.

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

- The function and how the function should be standardized

There should be standardized business associate and data sharing agreements available to providers. These can be "templates" which could be altered or negotiated based on unique terms and conditions.

- The pros and cons of standardizing the function

Through no fault of their own, smaller providers do not have the scale or the expertise to effectively contract with MCOs in meaningful ways. While there could be a greater effort to leverage a "brokerage" model of contracting between similar provider types, this sort of standardization would be helpful. The State of Ohio could also form a "business services" section of Medicaid focused on contractual assistance for these providers.

- The potential barriers to standardizing the function and ideas for addressing them

Part of the purpose of managed care is to allow for competition among providers to effectively negotiate terms that lead to the best outcomes. Standardization may lead to less innovative practices in order to achieve the best terms. With that said, the state could implement an oversight function and limit the standardization to smaller provider organizations to ensure network adequacy.

Communication about policy updates

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

Simply, the larger the organization, the less likely the organization's providers are familiar with the MCO's policies. Specifically, for primary care departments within hospitals, a standard condition for contracting with hospitals should be dependent on distributing annual updates with policy changes to these providers directly. The hospital administrative staff would be responsible for implementing and certifying the distribution. This information should include a number for any provider to call if they have questions for that plan, as well as a single number to call with the Ohio Department of Medicaid.

Plans should also host a single website where this information is stored as well.

Support for administrative requirements

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

MCOs should have a single source for billing inquiries unless other specific arrangements are made in specific contracts with a provider. This should include a single webpage with information on billing process and contracting.

Data sharing

17. How could data sharing between the state, managed care plans and providers be improved? In particular:

• What data do providers want access to that they do not have access to today; how would providers use that data?

Providers need more access to utilization data and consumer information. This can be reciprocal where MCOs would be able to access CliniSync for their members.

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

This should be available through a provider portal but also through the designated case manager for any given enrollee. If there is no case manager, a customer service representative should be able to assist. One major source of data should be the risk assessment conducted by MCOs.

• Are there barriers to providing the requested data; how could those barriers be overcome?

Larger provider organizations may have administrative barriers, internally, which prevent this sort of access. Also, competition between providers and MCOs for case management makes this process of data exchange more difficult, so the state should intervene and outline specific recommendations or create a reimbursement penalty (automatic rate reductions, for example).

• How could data be shared and used by providers that have limited resources and technology?

The state could consider developing provider fees that could be used to draw down federal funds for these purposes. Additionally, for the Developmental Disability Boards (DD Boards) and Alcohol, Drug Addiction and Mental Health Boards (ADAMHS Boards) should be engaged to determine how they may be able to play a role in the capacity building of local providers.

18. Describe how managed care plans could support primary care providers in integrating care for individuals enrolled with them. In particular:

• What kind of primary care infrastructure may be needed?

Better connections to community organizations by having MCOs work with non-medical providers to address needs and ensure a closed loop with the PCP. From an infrastructure perspective, this includes the health information exchange and legal constructs necessary to effectuate care.

• What kind of training or coaching may be needed?

MCOs have resources for quality improvement based in continuous improvement science. These resources should be a collaborative endeavor between the providers and MCOs and reinforced in the reimbursement logic of Medicaid.

• How could the state/managed care plans incentivize primary care providers to improve access to care?

The state should encourage MCOs to recalibrate rates away from acute care to primary care. Simply, MCOs should pay less for inpatient care and put the reduction of those rates directly into primary care.

• What kind of primary care models should be encouraged by the state/managed care plan?

Patient Centered Medical Homes are a proven model with structures that are known and comparable. That said, primary care should be considerate of non-medical services and community-based organizations should be co-creators in the case management functions of the beneficiaries involved. Other than that, screening tools based in social determinants, adverse childhood events and trauma should be the standard course of care.

Workforce development

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

It is critical that MCOs provide sufficient feedback to providers regarding their access to appropriate levels of care and healthcare providers. Providers need to inform MCOs of the availability or lack thereof of appropriate levels of care and healthcare providers. This information needs to go to the relevant state departments, e.g., the Ohio Department of Mental Health and Addiction Services (OMHAS), which are working on workforce development strategies. Increased use of telemedicine would be appropriate for some of these services.

ODM should collaborate with relevant state agencies to explore various strategies for 'forgiving' student loans for those who choose to enter the 'public' social services professions, including waiving licensing fees and future costs of continuing education requirements. In order to build a sustainable work force, concrete incentives must be available. Additionally, graduate medical education add-on payments should be retooled to focus on primary care and behavioral health, diminishing the resources available for specialists.

Payment innovation

20. What are some ways the state/managed care plans could prepare and assist providers to move through the continuum of shared accountability models that reward providers for quality and improved health care outcomes? In particular:

• How could the state or managed care plans support and increase the establishment of comprehensive primary care practices and/or accountable care organizations?

If MCOs and providers develop downside risk models, MCOs should be subject to less risk in their payments.

If accountable care organizations (ACOs) are allowed, providers should be held to the same standards as the MCOs, including standards around a medical loss ratio built on net income

before investments are made. Moreover, a feasibility statement should be made relative to an ACO's ability to process claims at the same volume of what would be available before the establishment of the ACO. Last, ACOs should have requirements for the inclusion of community-based organizations (CBOs) in governance and operational structures with clear, measurable standards relative to improving the health of populations.

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

When high-fidelity wraparound services are included in the state plan, then local access, either through Family and Children First Councils (FCF) or the provider, should offer free, flexible funds to be used to access non-Medicaid services and supports which can help offset family disruption/crisis (e.g., transportation, short term housing stipend, memberships, etc.).

In addition, the mandatory risk assessment should have an impact on the rate cell construction of the MCOs with a specific contemplation of social determinants of health. If the MCOs are successful assisting clients achieve better health, the state should have resources available to prevent "premium slide" of high-performing MCOs.

The state could also consider a pay for performance program specific to social determinants that is separate from the downside/withhold program recently created. For any dollars which are not awarded, funds should be deposited into the Recoveries Fund of the Department and intergovernmental transfers could be made to other state accounts that support the social determinant categories developed by the state. For example, if housing insecurity is an element of this measurement, any funds not awarded could be divided into other programs which support housing such as the Ohio Housing Trust Fund and the Lead Safe Home Fund.

Lastly, the state should examine policies relative to "in lieu of" standards in the MCO rule, and ways to leverage medical loss ratio and market share as a function of its risk-based payments. For those plans that perform better relative to specific populations, they should be rewarded with less risk and greater market share of enrollees. Specifically, the Department should reward plans with a greater market share for both parents and children for those plans who actively do outperform their peers, nationally, in meeting federally-required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) expectations.

Other

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

As previously stated, MCOs should proactively reach out to providers for their highest risk beneficiaries and/or those beneficiaries who are identified as priority populations in the State Health Assessment and State Health Improvement Plan.

Benefits and Delivery System

Value-added services

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

It would seem important for the state to address the role of EPSDT within an MCO environment. If services that are not currently in the state's Medicaid plan are identified through the development of an individual care plan as necessary, how do MCO and providers address this? EPSDT allows for Medicaid reimbursement for services not only in a particular state's plan but also for services that are covered in another state's plan. [4]

Delivery system model

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

Multi-system youth enrolled in Medicaid require professionals with expertise in working across systems on the care coordination, clinical and fiscal aspects of care. Also, the approach for children and youth needs to be embedded in a family plan of care. For youth enrolled in special education, the services and supports they may receive at school or through school would need to be coordinated with services within the scope of their MCO. MCOs should be familiar with the evidence-based practices that are used in the state for youth with behavioral health conditions. This will be increasingly important with the implementation of the Family First Prevention Services Act (FFPSA) in the child protection system.

In addition to populations identified above, the state should contemplate geography as a potential population category beyond those currently defined in the Provider Agreement via the Equity Institute Communities for infant mortality. ZIP codes carry with them a high-level of predictability in outcomes and denote myriad factors affecting health (race, housing, transportation, economic opportunity, etc.).

The only issue in defining any of these populations is the ways in which volume can diffuse impact of the interventions. Therefore, the state should roll out populations of focus in deliberate ways and at a reasonable schedule.

Access to pharmacy benefits

24. One area that has resulted in national attention and is of significant concern is the administration of pharmacy benefits.

- What problems have individuals enrolled in managed care plans had with accessing pharmacy benefits? Has that included, for example, challenges with getting certain kinds of medications?

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

[4] https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

The state could consider closing the formulary and/or develop a lock-in for high utilizers that allows MCOs to close contracts with lowest cost pharmacy.

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

The state should seek a waiver to create a closed formulary. Additionally, the state should consider leveraging 28 United State Legal Code 1498 and facilitate the mass manufacturing of any drugs which substantially increase in price. Drugs associated can be manufactured at a reasonable amount to cover costs and should be made until a reasonable volume is achieved or the price achieves a loss ratio standard of at least 15 percent.

Integration of behavioral health and physical health services

26. The state understands that coordination and integration of service delivery improves the experience and overall health of individuals enrolled in managed care plans yet providing well-coordinated and holistic health care can be challenging to individuals and providers alike.

Discuss any suggestions you have for improving the integration of services, particularly the delivery of behavioral health and physical health care. Include your ideas about:

- Improving communication and consultation across providers
- Shared assessment and service planning
- Data and information exchanges

This is particularly challenging in a system which does not have a consistent level of care tool/process for youth in the behavioral health system. Nor does the system have any consistent mechanism for collecting clinical outcomes data. Physical health care should routinely include screening for trauma (ACEs). Medical doctors who prescribe medications (for behavioral health conditions) to children and youth need to participate in any cross-system collaboration with multiple providers and systems.

The state should consider assessing a fee for behavioral health providers that would be used to draw down funds to build additional capacity. Specifically, the state should look at community behavioral health and use the fund draw down to help these providers develop an electronic health records infrastructure that can meaningfully communicate with other parts of the delivery system, though it should explicitly exclude hospital systems which have benefitted from previous health record infrastructure payments.

The EQR also made reference to increasing MCOs' school-based health care engagement as a strategy to address the behavioral health needs of youth. This is a good recommendation given the opportunity to impact children where they spend significant time. For any children identified by the school as having a behavioral health issue, the school should be encouraged to work with an MCO to coordinate a medical home (where one does not exist) and/or an ACEs screen. For children who have been identified as having a high ACE score, the MCO should work with the provider and the school to coordinate resources to mitigate the negative impact of those ACEs.

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

The issue of access to these services is more related to their availability. The state has extremely limited availability of EBPs for youth and families. While many good programs are represented in the state, the numbers served are relatively low due to limited capacity. ODJFS has compiled some data on the availability of EBPs through their (Family First Prevention Services Act) FFPSA planning process. What is needed is support at the state budget/policy levels to make strategic and concerted investments in EBPs across the state. Again, with the upcoming implementation of FFPSA in the child protection system, the role of EBPs will raise the level of expectation for home and community-based, evidence-based practices. All state departments that serve children, youth and families need to follow the same strategies to increase evidence-based and promising practices.

Care coordination/care management

28. Individuals enrolled in managed care plans with chronic or complex health conditions may have multiple agencies involved in the management and coordination of their care, such as the managed care plan, the primary care provider, a behavioral health provider, or another state Agency.

- What are ways the state/managed care plans could improve the management and coordination of care for individuals with chronic or complex health conditions?

  The current MCO data system is based on direct experience with claims and is thus retrospective. MCOs should have better access to clinical information.

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

This is a critical decision point in the delivery of care. The state needs to consider different models of care coordination within a system of care framework, particularly for youth and families that are involved in multiple systems.[5] These different models could be proposed within a discussion that involves both MCOs, providers and families to determine what structure might be most adoptable for Ohio's system.

To assist, the state needs to encourage more distribution of this care management where appropriate and provide incentives to do so. In the context of chronic disease management, PCPs may be in the best position, clinically, but many of the issues which underpin the management of these diseases are beyond the walls of a clinic.

[5] Pires, S., Fields, S, et.al., 2018 (in process) Care Integration Opportunities in Primary Care for Children, Youth and Young Adults with Behavioral Health Challenges: Expert Convening. National Technical Assistance Network for Children's Behavioral Health

The MCO should be empowered and encouraged to develop relationships with external, non-clinical partners to address those needs. If possible, and where appropriate, these community-based organizations should be brought in with the rest of a care team at moments of transition or, where appropriate, be a source of referral for certain services. When there is a referral, these community partners should close the loop with the care team, however it is defined, and outline any challenges or opportunities. If the population in question has a particularly high need, as is the case with multi-system youth or patients with serious and persistent mental illness (SPMI), the primary responsibility of case management should be contracted-out from the MCO to the agency in the best position to coordinate.

29. What expectations should the state have for managed care plans in performing care management activities to help individuals enrolled in managed care plans and providers manage chronic and complex health conditions? Consider the following in your response:

- Provider reimbursement strategies when the provider has a role in care management

For youth in the behavioral health system, it is hard to imagine that providers would not have a substantial role in care management. A continuum of care coordination/management would appear to be one avenue to pursue. Intensive care coordination really needs to take place in the most immediate proximity and includes the youth and family (see footnote 1).

To assist, MCOs should sub-contract out this care management function to such entities, though the state should ensure that any subcontractural relationship does not affect the overall financial wellbeing of the MCO.

- Managed care plan surveillance of data (e.g., admission/discharge, utilization of crisis services) and sharing information with providers

Sharing meaningful data should go beyond surveillance. MCOs, providers and individuals need to be in sync with what is being shared and have some degree of context for the data and information. Monitoring crisis services for children, youth and families can be a significant source of information to build out prevention, early intervention and intervention in behavioral health services.

- Whether there should there be higher expectations for certain populations (if so, which ones and why)

Children and youth with serious emotional disturbances (SED) and multi-system youth will require a level of care management that will likely be higher. Involvement in multiple systems (see response to #31 below) will make care coordination more challenging and there should be specific protocols to assure that these youth and their families are receiving coordinated care management.

The state should ensure that there is an equity framework in its efforts, contractually. To assist, there are tools the National Quality Forum has developed which provides guidance for states to address disparities and rural health.[6]

[6] https://www.qualityforum.org/NQFs_Roadmap_to_Health_Equity.aspx

Special populations

30. Are there barriers to the delivery and coordination of care for any of the populations listed below; if so, provide suggestions on how to improve the coordination and communication among providers and systems to prevent gaps in care or duplication of services.

• Children in foster care

See response to item 31. In addition, consideration will need to be given relative to the type of foster care placement: short term, long term, kinship. Each would carry different implications for the delivery of services and care management. Particular attention must be given to address the youth's potential traumatic responses to being removed from his or her home/community.

• Multi-system youth—

See response to item 31.

• Veterans
• People with disabilities
• Justice-involved individuals

See response to item 31. The state could also incentivize contracting with county jails to emulate other coordinated case management efforts with state prisons for individuals with behavioral health needs.

• Other individuals whose needs present special or unique considerations in a managed care system

Persons living with HIV should be a population that receives special attention from the state and serves as a good example where the diffusion of case management and specific quality measures may be helpful.

To explain, Ryan White providers, who have a legacy working with the HIV positive population, have a role in care management even after Medicaid has taken a greater role in coverage through expansion. Ryan White providers understand and have the cultural competency to develop strategies of care in ways that are effective, patient-centered, and built on a legacy of community trust. For these reasons, HIV positive individuals should not only be considered a special population in Medicaid, but can serve as an analogy for the state's thinking in other ways to de-centralize case management away from MCOs to settings of patient preference.

More specifically, a quality metric around viral suppression could be created with the achievement being a mandatory part of the shared case management process. In other words, when such providers create value for the MCOs, they should benefit financially. This can be accomplished singularly as a "value-add" fee through for this case management, a shared savings payment based on performance, or both.

Cross-system collaboration

31. How could coordination of services/programs managed by partner state agencies be improved? Include your recommendations for the role of the state agency, state agency case manager, managed care plan, provider, and individual enrolled in a managed care plan.

The level of care management and coordination revolves around the level of care needed by the individual. Historical care management tactics for minimally complex situations might well be addressed by the MCO. As the coordination needs increase in complexity, the greater the need for a higher level of coordination (and accompanying expertise) for those involved in multiple systems (particularly youth). With multi-system youth there may be several entities responsible for some aspect of care and monitoring. MCOs, providers, families and systems need to have a cohesive alliance so that these entities do not work at cross purposes or in conflict. Expectations by any one system may impact the others. The role of local FCF needs to be clarified, as was proposed in the Joint Committee's report on multi-system youth. MCOs need to understand the local role of the FCF.

Wherein the state provides funding to governmental agencies for the coordination of services, these agencies should have an outlined business associate's agreement and data sharing agreement in place with plans to effectuate the most appropriate coordination of services. For example, as Families and Children's First Councils receive money to coordinate care for children exposed to lead, the information relative to that case management should be shared with the MCO where the MCO serves in a supportive role to address any needs which may not be directly available through the council.

Population Health Considerations

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

As noted above, at this time the state does not require any universal level of care assessment tool nor any consistent clinical outcomes measurement. These assessments and outcomes would be the responsibility of the provider agencies. Some of the evidence-based and promising practices in the field identify specific outcomes that are used to determine success, such as, is the youth: in school (or employed), living at home or in the community, not engaged in the justice system, engaging with positive peers, etc. In addition, more clinical assessments (e.g., decrease in depression) can be made using standardized tools.

As the state starts to have the MCOs collect social determinant data through its risk assessment, this data should be aggregated, and the state should work with its federally-required actuary to determine how these factors affect cost as a matter of insurance risk. This should be described in a report, annually, and contemplated during the State Health Improvement Plan process.

33. Which entity or entities (e.g., managed care plan, primary care provider, other providers) are best suited to work on improving performance on population health measures? Does it vary by measure?

The state's most recent external quality review makes several recommendations in regards to quality improvement projects the MCOs should conduct and continue. This should be a shared responsibility of MCOs, providers and community organizations alike. Stakeholders currently conduct independent, quality improvements but rarely do so in concert. For especially high-risk populations, this work should be incentivized to be conducted collaboratively, potentially through the efforts of Regional Health

Improvement Collaborative (RHICs). If the projects achieve a certain scale and success, as determined by the state, the results should be provided to the Medical Care Advisory Committee (MCAC) and the Ohio Department of Medicaid for consideration as a standard in the delivery of care. In addition to MCAC, the state could host a webpage where these projects could be posted with information on how to replicate them and relevant contact information for MCO representatives if other organizations are interested in pursuing a similar project. If not through standardization, this information on shared experience in quality improvement should be aggregated and publicly available.

Performance Measurement and Management

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

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

- *Accuracy of PCP Assignment*
- *EPSDT completion rates*
- *HEDIS performance relative to national peers*
- *Elimination of disparities*
- *Security (housing and food access, specifically)*
- *Smoking cessation*

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

The current HEDIS measures have value in retrospectively determining performance, areas for improvement and assigning value through reimbursement. Per earlier recommendations, the state should examine and incorporate all the process measures and outcome measures identified by the National Quality Forum's Roadmap for Promoting Health Equity and Eliminating Disparities.[7] *Beyond this, the state should develop non-HEDIS measures which increase housing stability as the primary social determinant of health in need of redress.*

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

The current state's report card is not a useful tool, in totality. It should be more rigorous.

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

Greater attention needs to be paid to non-clinical factors and there are a number of ways to determine that information currently in addition to the risk assessment. The risk assessment conducted by the plans should be the primary resource for social determinant information and should be leveraged to inform reimbursement logic relative to incentives.

[7] https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86035

Per earlier recommendations the state should also examine and incorporate all the process and outcome measures identified by the National Quality Forum's Roadmap for Promoting Health Equity and Eliminating Disparities.

General Feedback

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

Greater direct connection and coordination between PCPs and case managers around common beneficiaries.

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

The state should develop its own version of New York's Statewide Planning and Research Cooperative System (SPARCS). This is a comprehensive all-payer data reporting system that collects patient-level detail on patient characteristics, diagnoses, treatments, services and charges for each hospital inpatient stay and outpatient (ambulatory surgery, emergency department and outpatient services) visit; and each ambulatory surgery and outpatient services visit to a hospital extension clinic and diagnostic and treatment center licensed to provide ambulatory surgery services. This resource would enhance Ohio's current efforts to define value and create useful comparative information that would serve the public, providers and payers alike.

If this system is developed, it should also display key MCO information including consumer metrics such as application processing times, wait times, abandonment rates, quality performance and satisfaction scores.